

PL3 Request an additional attempt at PLAB 1 or PLAB 2

Section A - Details of application

Applicant name	Applicant name
Applicant email address	Applicant email address
GMC reference number	
What was the date of your previous attempt at the PLAB test?	

My application is supported by

Select which evidence you are sending to support your application and follow the instructions

Structured reports covering at least 12 months' clinical work experience, over the last two years, since my last attempt at PLAB.	✓	Complete sections B and C
A postgraduate clinical qualification certificate gained over the last two years, since my last attempt at PLAB.	✓	Complete sections B and D

Section B - Details of activities since your last attempt

To be eligible for an additional attempt at the PLAB test we have to be satisfied that you have taken appropriate steps to improve your clinical knowledge and skills. Please outline the activities you have undertaken since your last attempt and how your knowledge and skills have improved as a result.

Section C – Details of recent clinical work experience and structured reports supporting this application

Clinical work experience Period 1	Period from	to
	d d m m y y y y	d d m m y y y y
Senior doctor name and job title	Senior doctor name	Senior doctor title
Place of employment	Place of employment	
My job title	My job title	
Were you engaged in active clinical practice involving direct patient contact?	Yes <input checked="" type="checkbox"/>	No <input checked="" type="checkbox"/>

Clinical work experience Period 2	Period from	to
	d d m m y y y y	d d m m y y y y
Senior doctor name and job title	Senior doctor name	Senior doctor title
Place of employment	Place of employment	
My job title	My job title	
Were you engaged in active clinical practice involving direct patient contact?	Yes <input checked="" type="checkbox"/>	No <input checked="" type="checkbox"/>

Clinical work experience Period 3	Period from	to
	d d m m y y y y	d d m m y y y y
Senior doctor name and job title	Senior doctor name	Senior doctor title
Place of employment	Place of employment	
My job title	My job title	
Were you engaged in active clinical practice involving direct patient contact?	Yes <input checked="" type="checkbox"/>	No <input checked="" type="checkbox"/>

Clinical work experience Period 4	Period from	to
	d d m m y y y y	d d m m y y y y
Senior doctor name and job title	Senior doctor name	Senior doctor title
Place of employment	Place of employment	
My job title	My job title	
Were you engaged in active clinical practice involving direct patient contact?	Yes <input checked="" type="checkbox"/>	No <input checked="" type="checkbox"/>

Section D – Details of postgraduate clinical qualification completed

Title of postgraduate qualification	Title of postgraduate qualification						
Awarding body	Awarding body						
Result	Result						
How was the course delivered? Select which one applies to you							
Taught	<input checked="" type="checkbox"/>	Online	<input checked="" type="checkbox"/>	Distance learning	<input checked="" type="checkbox"/>	Other	<input checked="" type="checkbox"/>
Was the course full time or part time?	Full time or part time						
Dates from commencing course to awarding date	Commencing from			Awarding date			
Name and title of Senior Educational Supervisor	Name of Senior Educational Supervisor			Title of Senior Educational Supervisor			
Email address of Senior Educational Supervisor	Email address of Senior Educational Supervisor						
<p>Please enter details of the course content explaining the clinical element(s) included. You should attach a copy of the course curriculum including each component.</p>							

Section E – Your declaration

I declare that the information I have provided is true and accurate to the best of my knowledge. I understand that it will be used by the GMC, as part of the evidence for deciding whether I am eligible for an additional attempt at the PLAB exam.

Please return the form to us either by email or by post.

Email	<ul style="list-style-type: none">• Please date and either insert an electronic signature or simply type your name into the signature field below.• Click on the 'Submit Form' button in the top right hand corner.• If you have any problems submitting the form, please email it to plab@gmc-uk.org.		
Post	<ul style="list-style-type: none">• Please sign and date in the space provided below.• Post to General Medical Council 3 Hardman Street Manchester M3 3AW		
Name	<input type="text" value="Name"/>	Date completed	<input type="text"/>
Signature	<input type="text"/>		