

PL4 Structured report form to support request for additional attempt at PLAB 1 or PLAB 2

What is this form for?

This form is to support the candidates request for a final additional attempt at either PLAB 1 or PLAB 2 test. Read about the PLAB test at <http://www.gmc-uk.org/plabemployerinfo/>.

How should I return this form to you?

Enter the details and click on the 'Submit Form' button in the top right hand corner. If you have any problems submitting the form, save a copy of it and email it to plab@gmc-uk.org.

Applicant information

Applicant name	<input type="text" value="Applicant name"/>
GMC reference number	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>

Referee information

Name and occupation	<input type="text" value="Name"/>	<input type="text" value="Occupation"/>
Place of employment, training or educational institution and address	<input type="text" value="Place of employment, training or educational institution and address"/>	
Your telephone number	<input type="text" value="Your telephone number"/>	
Email address	This should be an official work email address not a webmail address such as Hotmail or Googlemail <input type="text" value="Your email address"/>	
Do you hold registration with the GMC? If yes, state your GMC reference number	Yes <input checked="" type="checkbox"/>	No <input checked="" type="checkbox"/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>
If outside of the UK, do you hold registration with any other medical regulator? If yes, state the name of the regulator	Yes <input checked="" type="checkbox"/>	No <input checked="" type="checkbox"/> <input type="text" value="Name of medical regulator"/>

Relationship to applicant (either Senior Clinical Supervisor or Senior Educational Supervisor)	<input type="text" value="Relationship to applicant"/>	
Dates supervising applicant	From <input type="text" value="d"/> <input type="text" value="d"/> <input type="text" value="m"/> <input type="text" value="m"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/>	To <input type="text" value="d"/> <input type="text" value="d"/> <input type="text" value="m"/> <input type="text" value="m"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/>
<p>If you are returning this form by post or scanned email, the official stamp of the organisation must be stamped over this section and every page of this report. If you do not have an official stamp please submit this report under cover of a letter on headed paper from your hospital / university / institute.</p>		<input type="text" value="Stamp"/>

Referee information (continued)

Please state the applicant's job title/ role and their responsibilities?	<input type="text" value="Applicant job title / role and responsibilities"/>	
Type of employment / study that applicant was engaged in	Full time <input checked="" type="checkbox"/>	Part Time <input checked="" type="checkbox"/>
Title of postgraduate course attended (if applicable)	<input type="text" value="Title of postgraduate course"/>	

Knowledge, Skills and Experience

Based on your knowledge of the applicant please assess his/her capabilities in the following areas:	Met standard required	Did not meet standard required	Unable to assess
Quality of work undertaken	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Clinical knowledge and skills	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Ability to work collaboratively with colleagues to maintain or improve patient care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Ability to act with honesty and integrity	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Ability to treat patients and colleagues fairly	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Desire to learn and improve their knowledge and skills	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
If you have rated any of the above as 'Did not meet standard required', please outline why below			
<div style="border: 1px solid #ccc; height: 200px;"></div>			

Any further comments

If you wish to add any further comments about this individual's application to the GMC for an additional attempt at the PLAB exam, please use the space below.

Your declaration

The information I have provided in this form is accurate and true.

I understand that the GMC may make any necessary checks to verify the information I have given.

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	<table border="1"><tr><td>Name</td><td></td><td>Date</td><td>d</td><td>d</td><td>m</td><td>m</td><td>y</td><td>y</td><td>y</td><td>y</td></tr></table>	Name		Date	d	d	m	m	y	y	y	y
Name		Date	d	d	m	m	y	y	y	y		
Signature	<input type="text"/>											