**Medical information form for Access Arrangement applications**

**This form can be used by candidate’s applying for access and inclusion arrangements to help them to collate evidence to support their application.**

**Please submit this form, along with your application form to** [**exams@actuaries.org.uk**](mailto:exams@actuaries.org.uk)

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| **Part A** of this form should be completed by the candidate. **Part B** should be completed by a health and/or educational professional.  The IFoA relies on advice from health and/or educational professionals when reviewing applications for access and inclusion arrangements. | | | | | | |
| **Part A - To be completed by the candidate** | | | | | | |
| **Full Name of candidate** | |  | | **ARN** | |  |
| **Do you have a clinical diagnosis? Y/N** | | | | | | |
| **Diagnosis:** | | | | | | |
| **Date of the diagnosis:** | | | | | | |
| **What is the likely duration of the condition(s)?** i.e., is this a **temporary** or **permanent** condition | | | | | | |
| **How stable is your condition(s)?** i.e.is this a **static** or **fluctuating** condition | | | | | | |
| **Can you please give details of the symptoms you experience?** | | | | | | |
| **How could these symptoms impact upon your ability to access and undertake examinations?** | | | | | | |
| **Medication(s)** – Do you experience any side effects and how do they affect your function when sitting examinations? | | | | | | |
| **Please list coping strategies you have used to manage your symptoms/condition(s)** | | | | | | |
| **Recommendation(s) –** please identify what adjustments you have previously had for examinations. If you have previously received extra time or rest breaks, then specify the amount you have previously had. | | | | | | |
| **Part B –To be completed by the medical professional** | | | | | | |
| **Please confirm the clinical diagnosis:** | | | | | | |
| **Medication(s)** - please indicate the possible impact any medication prescribed to the Candidate may have upon the ability to undertake examinations, *for example some medication can make candidates feel drowsy and sluggish first thing in the morning.* | | | | | | |
| **Access arrangements recommended:** Please select the access arrangements you are recommending (you can select more than one):  Extra time, please specify: \_\_\_\_ %  Rest breaks, please specify: \_\_\_\_ %  Use of scribe  Use of speech recognition software  Use of computer reader  Use of reader  Permission to handwrite  Other: \_\_\_\_ | | | | | | |
| **Comfort Aid requirements -** Please select the comfort aids you are recommending (you can select more than one):  Bandages that obscure the face and cannot be removed to verify your personal identification.  Eye Patch  Medical device that makes noise. Name of the device: \_\_\_\_  Continuous Glucose Monitor  Insulin Pump  TENS Unit  Oxygen Tank that makes noise, or where it requires an external remote-control device.  Noise reducing headphones  Dictation headphones  Face mask  Music or noise machine, for example a white noise machine | | | | | | |
| **Additional requirements to be shared with the invigilator-** Please select which are applicable (you can select more than one):  Rest breaks can be used for moving and stretching etc.  Rest breaks can be used for leaving the room, e.g. for toilet breaks.  Other, please specify: \_\_\_\_ | | | | | | |
| **How long would you recommend these adjustment(s) are put in place for?** Please recommend a length of time, e.g. 1 year. | | | | | | |
| **Signature:** | | | **Name:** | | **Date:** | |
| **In what capacity are you signing this form? (e.g. G.P. / Consultant):** | | | | | | |

# Please validate this form with your official stamp or state your title, name, address, telephone number & email address in case of a query.