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| IFOA_logo_ | **Medical information form for Access Arrangement applications** |

**This form can be used by candidate’s applying for access arrangements in order to help them to collect evidence to support their application.**

**This form should be submitted with the candidate’s access arrangement form to:**

Email: [education.services@actuaries.org.uk](mailto:education.services@actuaries.org.uk) *(Preferred)*

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| **Part A of this form should be completed by the candidate. Part B should be completed by the medical examiner. The IFoA relies on advice from medical examiners in order to put the appropriate reasonable adjustments and support in place.** | | | | | | |
| **Part A - To be completed by the candidate** | | | | | | |
| **Full Name of candidate** | |  | | **Date of Birth (dd/mm/yyyy)** | |  |
| **Do you have a clinical diagnosis? Y/N** | | | | | | |
| **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?** | | | | | | |
| **What symptoms do you experience and how could these impact upon your ability to access and undertake examinations?** | | | | | | |
| **How might the symptoms affect academic tasks, particularly when sitting formal exams?** | | | | | | |
| **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 or identify adjustments you require.  This must be quantified if extra time or rest breaks is recommended. – *For example, a percentage of extra time, or number of minutes for rest breaks.* | | | | | | |
| **Part B – To be completed by the medical professional** | | | | | | |
| **Please confirm the clinical diagnosis:** | | | | | | |
| **Please list prescribed medication:** | | | | | | |
| **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.* | | | | | | |
| **Recommendations of what adjustments are required to the examinations:**  This must be quantified if extra time or rest breaks is recommended. – *For example, a percentage of extra time, or number of minutes for rest breaks.* | | | | | | |
| **How long would you recommend these adjustment(s) are put in place for?** | | | | | | |
| **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.