Requesting a reasonable adjustment in the registration assessment: application B

**Use this application to request a reasonable adjustment if you have a condition which is not covered by a learning needs assessment. If you are requesting an adjustment for more than one condition not relating to a specific learning need, you must complete a separate application for each condition. You will need to ask a suitable qualified health professional to complete this form with you.**

**Information for the qualified healthcare professional completing this form**

You are being asked to provide information to support the request for a reasonable adjustment in the registration assessment, a professional examination that candidates must pass to register as a pharmacist in the UK. You can find out more about how the assessment is carried out by [reading the assessment specification on the GPhC website](https://www.pharmacyregulation.org/requesting-reasonable-adjustment-registration-assessment).

You must **only** complete the form if you are involved in the individual’s care in relation to the specific condition the candidate has outlined in the form.

The candidate’s adjustment request will be assessed by a panel of professionals.

* The candidate **must** fill in sections 1 and 4
* Only then can the healthcare professional complete sections 2, 3, and 6.
* Then return the application form to the candidate for submission

**Please ensure the applicant has completed their sections before you complete your sections of the form.**

We may contact you to check the information you have provided.

Please complete the form using MS Word or print it out and fill it in by hand. There are instructions on how to sign the form electronically at the beginning of section 6.

If you have any questions about the process, please contact us at [adjustments@pharmacyregulation.org](mailto:adjustments@pharmacyregulation.org).

#### Information for candidates

#### Completing your application

You must fill in sections 1 and 4 before you submit the application to your healthcare professional. Once your healthcare professional has completed sections 2, 3 and 6, and you have checked the application form, please complete section 5.

You can fill in the application form by using Word, or by hand and either:

1. save it as a PDF and sign it electronically, using the Adobe Acrobat ‘Fill & Sign’ functionality. Activate Fill & Sign by clicking on the pen icon in the Adobe toolbar, so that you can complete the form using the text, checkbox and signature options. You can find out more about using [Fill & Sign on the Adobe website](https://helpx.adobe.com/uk/acrobat/using/fill-and-sign.html); or
2. print out the completed form, sign by hand and submit a scanned PDF copy.

We will not accept signatures that have been typed out.

It is your responsibility to ensure that all insertions on the form are legible.

#### Submitting your form

Send your completed form and evidence to: [adjustments@pharmacyregulation.org](mailto:adjustments@pharmacyregulation.org).

Make sure you:

* include all the documents you need to support your request, clearly scanned, or copied.
* send your application and documents as a single PDF file with no access restrictions.

We will not accept applications and evidence submitted to us in any other formats. You are responsible for making sure your application file is legible and accessible.

It is your responsibility as the applicant to make sure you send us the documents and information set out in the application guidance. If we receive your application and find that there is information outstanding, where possible, we will contact you to request this. Please be aware that if you send your application to us close to the submission deadline and there is anything outstanding, we may ask you to submit the required information within a short time or may have to submit your application in its current state.

#### Next steps

When you submit your application, you will receive an automatic email response within an hour to let you know we have received it.

You will receive an individual acknowledgement email from us within five working days of you submitting your request, to let you know that your application has been reviewed.

If you have not received an automatic response or acknowledgement email within the time frames above, it may mean that we have not received your application. If you do not receive an email confirmation, contact us at [adjustments@pharmacyregulation.org](mailto:adjustments@pharmacyregulation.org).

When submitting your application, it is your responsibility to ensure the address we hold for you on our records is correct as we will use this when planning and implementing any granted adjustments. If your address does change following this, you will need to update this via myGPhC and you must inform us as soon as possible. Please note, if you do change your address after the deadline, and you are granted adjustments, we cannot guarantee these will be implemented at your new location. This could mean you may have to travel to your previous location or further.

#### Help with your application

If you have any problems filling in this form, submitting evidence, sending your application by email, or any questions about making your application, please get in touch with us by email at [adjustments@pharmacyregulation.org](mailto:adjustments@pharmacyregulation.org) as soon as possible.

Requesting a reasonable adjustment in the registration assessment: application B

## Candidate details

**We will use the information you have provided in this section to track your application for an adjustment and to contact you about the outcome. The adjustments panel will use the information on the following pages to assess your application for an adjustment. You can** [find out more about how we use information in our privacy policy](https://www.pharmacyregulation.org/privacy-policy)**, available on the main GPhC website.**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title | Mr |  | Mrs |  | Ms |  | Miss |  | Other |  |

|  |  |
| --- | --- |
| First name |  |

|  |  |
| --- | --- |
| Last name |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| GPhC or Pharmaceutical Society NI candidate training number |  |  |  |  |  |  |  |
|

|  |  |  |
| --- | --- | --- |
| Your location (this will be used to implement any granted adjustments) | City: | Postcode: |

|  |  |  |
| --- | --- | --- |
| Which assessment sitting are you planning to sit? | Month: | Year: |

## Qualified professional details

**Please give your professional details below. We may use these to check your registration and to contact you about the information you provide in this form.**

|  |  |
| --- | --- |
| Name |  |

|  |  |
| --- | --- |
| Position, Profession, or qualification |  |

|  |  |
| --- | --- |
| Regulatory / professional body |  |

|  |  |
| --- | --- |
| Registration number |  |

|  |  |
| --- | --- |
| Contact telephone number |  |

## I can confirm I am not/have not been involved in the candidate’s foundation training as a designated supervisor/tutor and am only involved in their healthcare

**Yes**  **No**  **If no, please provide a letter to confirm how you are involved in their care for the condition the candidate is requesting an adjustment for.**

## Health condition diagnosis and impact

#### Part A: diagnosis

* 1. **Please give details of the candidate’s diagnosis, including how their condition is being actively managed (e.g., on a daily basis):**

|  |
| --- |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |

* 1. **Date of the diagnosis:**
  2. **Has the candidate had substantial sustained engagement for their condition?**

**Yes**  If yes, move to 3.5 **No**  If no, move to 3.4

* 1. **Prior to recent interaction to complete the form, when was the last time the candidate had a consultation/appointment to discuss and/or manage their condition?**

|  |
| --- |
|  |

* 1. **If you did not make the original diagnosis, please provide the qualification of the healthcare professional who originally diagnosed the candidate:**

|  |
| --- |
|  |

* 1. **Has this diagnosis been made within the last 12 months?**

**Yes**  **No**

* 1. **Is the condition likely to last for 12 months or more?**

**Yes**  **No**

* 1. **Is the condition temporary, or ongoing?**

**Temporary  Ongoing**

* 1. **Does the condition have a substantial impact on the candidate’s daily living?**

**Yes**  **No**

* 1. **If yes, please explain the substantial impact of the condition.**

|  |
| --- |
|  |

#### Part B: impact of the assessment process

To answer these questions, you may find it helpful to refer to the registration assessment specification, which explains how the assessment is carried out.

* 1. **In your opinion, are the adjustment(s) the candidate has requested in section 4 appropriate and proportionate to mitigate the effect of the candidate’s condition? If you do not agree, or partially agree, please provide further information.**

**Please include any information about the candidate, or their condition(s), that you think the panel should be aware of.**

|  |
| --- |
|  |

Thank you for the information you have provided. Please now complete the declarations in section 6.

## Reasonable adjustment

* 1. **List the adjustment(s) you are requesting. It’s important that you set out clearly the changes you want to be made to the assessment environment so that we can assess if these are appropriate for the condition set out in the diagnosis above.**

|  |
| --- |
|  |

* 1. **Are you requesting extra time?**

**Yes**  **No**  If no, please go to question 4.3.

1. **If yes, the below times are available. If you have submitted more than one application, please indicate the total allocation of time you want to request for this sitting considering all conditions declared across all applications, ensuring you only tick one box:**

**25%**  **35%**  **50%**  **100%**

Please note that the standard amount of extra time given is 25%. If you want to request more than 25%, the qualified healthcare professional will need to **specifically explain why the amount of time you want to request is necessary.**

* 1. **Are you requesting a seating arrangement? All seating arrangement requests, must be supported by the healthcare professional involved in your care.**

**Yes**  **No**  If no, please go to question 4.4

1. **If yes, please indicate what seating arrangements you require.**

**Sole occupancy room  Small room  Seated in a particular part of the room  Other**

1. **If you ticked sole occupancy room, please explain how a sole occupancy room will support you:**

|  |
| --- |
|  |

1. **If you indicated you need a small room, seated in a particular part of the room or other, please specify below what you require, and how this will support you:**

|  |
| --- |
|  |

* 1. **Tell us why you feel you may be disadvantaged during the assessment by explaining each of the following:**

1. **How the condition you have requested an adjustment for impacts you daily:**

|  |
| --- |
|  |

1. **How the condition will impact you in the assessment:**

|  |
| --- |
|  |

1. **How the adjustment(s) requested will prevent you from being disadvantaged:**

|  |
| --- |
|  |

1. **How you manage your condition, for example, through a treatment plan, medication etc:**

|  |
| --- |
|  |

## Candidate application declarations

I declare that:

* 1. **I have read and understand the guidance for requesting a reasonable adjustment in the registration assessment on the GPhC website.**

**Yes**  **No**

* 1. **To my knowledge, the information I am submitting in this form and provided to the qualified healthcare professional who has also completed it, is accurate and complete.**

**Yes  No**

* 1. **I understand that the information I have given in this form will be used by the GPhC’s adjustments panel to decide whether the adjustment I have requested is reasonable.**

**Yes  No**

* 1. **For GPhC candidates only - I understand and accept that this information may also be used in the future to decide on an application for entry to the register or to assess my fitness to practise, and that the GPhC may ask for updated information at any such time for these purposes.**

**Yes  No  N/A (Pharmaceutical Society NI candidates)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |

Signed Date

**Adding your signature using Adobe Fill & Sign**

Save a copy of this form as a PDF and open it in Adobe. Click on the ‘sign’ icon in the Fill & Sign toolbar and select ‘Add signature’. You can add your signature in two ways:

Click on the ‘Draw’ icon and use your mouse to draw your signature (as you would when accepting a package delivery)

Click on the ‘Image’ icon (first you will need to take a photograph of your signature and save it to your PC) and then select the image you have saved of your signature.

**Please note that we will not accept a typed signature.**

## Qualified professional application declarations

I declare that:

* 1. I have read the information provided by the applicant in sections 1 and 4 of this form and I have completed sections 2, 3 and 6 with reference to the candidate’s information.

**Yes  No**

* 1. I have provided the information in this statement in my capacity as an appropriately qualified professional involved in this individual’s care, in relation to the specific condition described.

**Yes  No**

* 1. The information I have provided above is true and accurate to the best of my knowledge.

**Yes  No**

* 1. I have read, and understand, the registration assessment specification and can confirm that I support the individual’s specific adjustment(s) requested in section 2 of their application in relation to this condition in the context of sitting the registration assessment.

**Yes  No**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |

Signed Date

|  |  |
| --- | --- |
| Print or type your name |  |

**See above to find out how to add your signature using Adobe Fill & Sign.**

**Please note that we will not accept a typed signature.**