ALTERNATIVE ASSESSMENT ARRANGEMENTS FORM

Please complete all sections and send with the duly filled exam application form at least four (4) weeks prior to assessment dates.

A. To be completed by Candidate/Parent/Guardian

Centre	Malta		Gozo		**Date of Exam**			

Candidate's Name		**ID Number**	
Teacher's Name		**Contact Number**	

Exam	Theory		Practical		**Level**		**Module**	

B. To be completed by a Professional Practitioner

Name of Disability or Medical Condition	

Please indicate which category the disability/condition best fits into:

Hearing		Mobility/Physical	
Vision		Neurological	
Learning		Medical	
Mental Health		Other*	
**In case of other please specify*			

List the Functional Impacts of the disability as they apply to this candidate. How does the disability or condition impact on the candidate's ability to perform? E.g. Inability to sit for long periods, fatigue, loss of concentration, medication effects etc. Further information may be attached.

1	
2	
3	
4	

Please indicate any specific recommendations for reasonable adjustments, in response to the functional impacts listed above that would assist this candidate to enable equal participation in an assessment situation.

Modified and enlarged print		Modified and enlarged print on low contrast pink paper	
Enlarged print		Enlarged print on low contrast pink paper	
Playback test to replace sight reading		Memory test to replace sight reading	
Extra time for sight reading/playback test		Extra time for theory exams	
Extra time for practical exams		Amanuenses	
Wheelchair access		Other*	
**In case of other please specify*			

Please tick the appropriate box or boxes below if you are recommending that extra time be allocated:

Working time		Resting time	

Supporting Documentation Attached*	Yes		No	

**Please note: Supporting evidence from relevant professional MUST clearly specify the alternative arrangements or equipment recommended and verification of why this is required and must be on letterhead of the professional practitioner.*

Name of Professional		Signature	

Stamp from practice must be supplied as verification.

Rubber Stamp

C. Consent of Parent/Guardian *(In case of candidate under sixteen (16) years of age)*

Full Name		Signature	

D. For Office Use

Approved		Declined		Date			