RANZCP Written Examinations

Special Consideration Request Form and Health Professional Report

The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Purpose of this form

Use this form to request special consideration where circumstances beyond your control are likely to adversely affect attendance, access or performance in an RANZCP examination. Complete Part A. For a health condition, disability, illness or injury, ask an appropriately qualified health professional to complete Part B. Information will be handled in accordance with the RANZCP Privacy Policy.

Important information for candidates

- Read the current RANZCP Special Consideration Policy and Procedure and submit this form with supporting evidence within the applicable timeframe.
- Describe the functional impact in the specific assessment setting and state the exact outcome or arrangement requested.
- The RANZCP will consider the evidence, assessment requirements, operational feasibility, assessment integrity and applicable competency standards. The requested outcome is not guaranteed.
- The RANZCP may request further information or contact the supporting practitioner to verify or clarify the documentation, with your consent.

Part A – Candidate request

Full name	
RANZCP ID	
Email address	
Telephone	
Candidate status	☐ Trainee ☐ Specialist International Medical Graduate (SIMG)

1. Examination details

Examination	
☐ Multiple choice question (MCQ) examination	☐ Modified essay question (MEQ) examination

Exam Date	

2. Type of special consideration requested

Select all that apply
☐ Prospective adjustment or special arrangement for an upcoming assessment
☐ Consideration of an acute event affecting performance
☐ Other outcome permitted under the policy: _____

3. Circumstances and functional impact

Primary basis of request	
☐ Ongoing health condition or disability	☐ Temporary illness, injury or condition
☐ Other: _____	

Date circumstances began	
Date you became aware they may affect the assessment	
Expected duration	

Describe the circumstances relevant to this request. *Avoid including unrelated personal or clinical information.*

Describe the specific functional impact on attendance, access or performance in this assessment. *For example: reading, writing or typing speed; concentration; fatigue; pain; mobility; sitting tolerance; communication; sensory access; medication or treatment effects; need for food, medication, toilet access or rest breaks.*

4. Outcome or arrangement requested

Specify the exact outcome or arrangement requested.
Be precise. For example: 10 minutes additional exam time per hour; one 10-minute rest break per hour with the examination clock stopped; use of a specific ergonomic device; separate room; access to medication.

Explain how the requested outcome or arrangement would address the functional impact.

Alternative arrangement that may be suitable if the preferred arrangement is not operationally feasible.

5. Existing or previous arrangements

Have you received related adjustments or arrangements?

At your workplace or training service - Yes ☐ No ☐

From the RANZCP for a previous assessment - Yes ☐ No ☐

From another education or assessment provider - Yes ☐ No ☐

Provide relevant details, including the arrangement, provider, and date.
Previous arrangements are contextual evidence only and do not determine the RANZCP outcome.

6. Supporting evidence included

Attach documents relevant to the request	
☐ Completed Part B – Health professional report (mandatory)	☐ Medical certificate or clinical letter (optional)
☐ Director of Training or principal supervisor support statement (mandatory)	☐ Hospital, emergency or attendance documentation (optional)
☐ Workplace adjustment plan (optional)	☐ Statutory declaration or other independent evidence (Optional)
☐ Other: _____	

Instructions to applications related to pregnancy and breastfeeding

Candidates requesting arrangements related to pregnancy or breastfeeding may submit a medical certificate or letter from their treating practitioner.
Completion of Part B is generally not required unless additional clinical information is needed.

6. Candidate's declaration and consent

- I declare that the information in this application and supporting documents is complete, true and correct to the best of my knowledge.
- I consent to the RANZCP collecting, using and disclosing the information to assess this request, administer any approved arrangement and meet recordkeeping or legal obligations.
- I consent to the RANZCP contacting the supporting practitioner or evidence provider to verify authenticity or clarify relevant functional impact and recommendations.
- I understand approval is not automatic, a different reasonable arrangement may be approved, and I must promptly notify the RANZCP if my circumstances change.

Candidate name	
Signature	
Date	____ / ____ /_____

Part B – Health professional report

Instructions to the treating health professional

Complete this section only where the request is based on a health condition, disability, illness or injury. Your report should focus on the candidate's functional capacity in the specific RANZCP assessment setting and the rationale for any recommended arrangement. Provide only information necessary for this purpose.

- You should be appropriately qualified, registered with AHPRA, MCNZ or another relevant regulatory body, and have sufficient clinical knowledge of the candidate and the condition.
- You must not be a member of the candidate's family, a close associate, a colleague with a conflict of interest, or a candidate in the same assessment or examination.
- A diagnosis alone is generally insufficient. Describe how the condition affects relevant assessment activities and whether current treatment, medication or existing support fully or partly mitigate that impact.
- Recommendations should be specific, clinically justified and proportionate. The RANZCP determines the final outcome after considering the assessment format and requirements.
- The RANZCP may contact you to verify this report or seek clarification, with the candidate's consent.

8. Health professional details

Full name	
Profession and specialty	
AHPRA / MCNZ / regulatory registration number	
Medicare provider number (if applicable)	
Practice or organisation	
Practice address	
Telephone	
Email	
Relationship to candidate	
Date first consulted for this condition	____ / ____ / _____
Date of most recent consultation *(Must be within 5 years for continuing conditions or 12 months for temporary illness, injury or condition.)*	____ / ____ / _____

9. Clinical information relevant to the request

Diagnosis or clinical description, where relevant.

Date of onset	____ / ____ / _____
Expected duration	☐ Temporary until: _____ ☐ Ongoing ☐ Episodic ☐ Uncertain
Current severity	☐ Mild ☐ Moderate ☐ Severe ☐ Variable

Describe the candidate's current treatment, management or supports relevant to the assessment *Include medication or therapy only where relevant to functional impact. Do not provide a full treatment history.*

To what extent do current treatment, medication or existing supports mitigate the functional impact in the assessment setting?	
☐ Fully – no material residual functional impact	☐ Partly – residual functional impact remains
☐ Not materially	☐ Unable to determine

Explain any residual functional impact, including relevant adverse effects of treatment or medication

Describe the specific functional impact under standard assessment conditions. *Address the relevant activities, likely frequency and severity. Examples include sustained concentration, reading, writing or typing, sitting, mobility, sensory access, communication, fatigue, pain, anxiety symptoms, or the need for clinically necessary breaks or access to medication.*

10. Recommended arrangement

Recommended arrangement(s)
☐ Additional exam time: _____ minutes per hour / total _____ minutes
☐ Rest breaks: _____ minutes every _____ minutes
☐ Separate or low-distraction room
☐ Ergonomic furniture or equipment: _____
☐ Assistive technology or alternative format: _____
☐ Access to medication, food, drink or toilet facilities: _____
☐ Other: _____

Explain how each recommendation directly addresses the identified functional impact. *Specify the amount, frequency, duration and any conditions required. Avoid general recommendations such as "extra time as needed".*

How long is the recommendation expected to remain applicable? *For example: this sitting only; until a specified date; for 12 months; ongoing subject to review.*

If the candidate's requested arrangement differs from your recommendation, explain why

11. Health professional declaration

- I confirm that I am an appropriately qualified health professional and have sufficient knowledge of the candidate and the circumstances described in this report.
- I confirm that I am not a member of the candidate's family, a close associate, a colleague with a conflict of interest, or a candidate in the same assessment or examination.
- I confirm that the information and recommendations provided are accurate, clinically supportable and limited to matters relevant to this request.
- I understand that the RANZCP may contact me to verify this report or seek clarification and that the RANZCP determines the final special consideration outcome.

Health professional name	
Signature	
Date	____ / ____ / _____

Privacy and further information

The RANZCP will manage personal and health information in accordance with its Privacy Policy and applicable privacy legislation. Information may be retained as part of the candidate's assessment record in accordance with RANZCP recordkeeping requirements.

For current policy requirements, submission instructions and contact details, refer to the RANZCP website or contact the relevant RANZCP assessment team.

For RANZCP use only

Date received	
Application complete	☐ Yes ☐ No – further information requested on: _____
Decision-maker / Committee	
Outcome	☐ Approved as requested ☐ Approved with variation ☐ Declined ☐ Other
Decision date	
Conditions / operational instructions	
Candidate notified	☐ Yes Date: _____ Method: _____