



**For Office Use Only:**

Personal ID No: \_\_\_\_\_

Candidate Examination No: \_\_\_\_\_

**EXAMINATION APPLICATION FORM**

**MEMBERSHIP OF THE FACULTY OF PODIATRIC MEDICINE**

**PART 2**

This form is to be completed in full and returned to **the Examinations Unit, Royal College of Physicians and Surgeons of Glasgow, 232-242 St Vincent Street, Glasgow, G2 5RJ**, by the published closing date for entry. The examination fee and all relevant documentation must be included with the application. Please refer to the guidenotes and checklist for applicants.

**Section 1 – Personal Details**

**Surname/Family Name:** \_\_\_\_\_

(block capitals)

**Other Name(s):** \_\_\_\_\_ **Title:** \_\_\_\_\_

(block capitals)

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ (day/month/year)

**You must state your name exactly as it appears on your primary qualification. Any candidate whose name has been changed must submit original or attested copies of documentary proof of this (e.g. marriage certificate) if they wish to be admitted to the examination in their new name.**

**Section 2 – Contact Details**

**Address (block capitals):** \_\_\_\_\_

\_\_\_\_\_

**Postcode:** \_\_\_\_\_ **E-mail Address:** \_\_\_\_\_

**Telephone:** **Daytime:** \_\_\_\_\_ **Evening:** \_\_\_\_\_

**Mobile:** \_\_\_\_\_

Note: Please notify the College of any change of address. If we need to contact you regarding your application, we will do so by e-mail in the first instance.

To be eligible to enter the MFPM Part 2 examination, candidates must provide satisfactory evidence of:

- Written confirmation of either a pass in Part 1 or written confirmation of exemption from the Part 1, granted through the exemption route.
- Experience in post-registration podiatric medicine practice, or equivalent, for a cumulative minimum of 3 years.

Completed sections overleaf must be signed **and** stamped by the relevant Employer/Referee. Should candidates be unable to obtain signatures on this form, the relevant details must be entered for each post and letters/certificates of verification attached containing the same declaration. **Only originals or attested copies will be accepted.** If you have any queries regarding certification of your professional development, advice can be obtained via email: [mfpm@rcpsg.ac.uk](mailto:mfpm@rcpsg.ac.uk)

### Section 3 – Examination details

Have you previously entered an examination through this College? (delete as appropriate) **Yes/No**

If Yes **Date:** \_\_/\_\_/\_\_ **Person ID Number** \_\_\_\_\_

Date of passing MFPM Part 1 \_\_/\_\_/\_\_ (day/month/year)

Or date exemption granted \_\_/\_\_/\_\_ (day/month/year)

Date and centre of Part 2 examination for which candidate wishes to appear:

**Date:** \_\_/\_\_/\_\_ **Centre:** \_\_\_\_\_

### Section 4 – Clinical Experience

#### Post 1

**Title:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Institution:** \_\_\_\_\_

**No. of Months:** \_\_\_\_ **Date From:** \_\_/\_\_/\_\_ **Date To:** \_\_/\_\_/\_\_

This is to certify that the above named applicant held the post above and that his/her declaration is a true statement of fact.

**Name of**

**Employer/Referee:** \_\_\_\_\_

(Block Capitals)

**Signature:** \_\_\_\_\_ **Date:** \_\_/\_\_/\_\_

**Official Stamp**

#### Post 2

**Title:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Institution:** \_\_\_\_\_

**No. of Months:** \_\_\_\_ **Date From:** \_\_/\_\_/\_\_ **Date To:** \_\_/\_\_/\_\_

This is to certify that the above named applicant held the post above and that his/her declaration is a true statement of fact.

**Name of**

**Employer/Referee:** \_\_\_\_\_

(Block Capitals)

**Signature:** \_\_\_\_\_ **Date:** \_\_/\_\_/\_\_

**Official Stamp**

**Post 2****Title:** \_\_\_\_\_ **Grade:** \_\_\_\_\_**Institution:** \_\_\_\_\_**No. of Months:** \_\_\_\_ **Date From:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Date To:** \_\_\_\_/\_\_\_\_/\_\_\_\_

This is to certify that the above named applicant held the post above and that his/her declaration is a true statement of fact.

**Name of****Employer/Referee:** \_\_\_\_\_

(Block Capitals)

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_**Official Stamp****IMPORTANT NOTES**

- a) Failure to complete any part of this application form or submit the required documentation may delay the application process and may result in you being unable to sit the examination at the requested diet.
- b) Copies of letters and certificates will be accepted only if they have been verified as a true copy. Attested copies must bear an original signature and official stamp (e.g. hospital stamp, public notary stamp). Official English translations from a translation agency will be required for stamps or certificates that are not in English.
- c) **Applications received after the closing date will not be accepted.**

**SPECIAL REQUIREMENTS**

It is the responsibility of the candidate to notify the Examinations Unit of any special requirements when they submit their application.

Applications for special consideration must be supported by written evidence in the form of a medical report from their General Practitioner or their Consultant Trainer. In certain cases, such as dyslexia, a current Dyslexia Assessment report from an educational psychologist will be required. In the case of a temporary disability due to ill health or accident which occurs after the application has been submitted, candidates must inform the Examinations Unit as soon as possible **before** the examination.

**DATA PROTECTION**

All personal information held by the Examinations Unit will be held in accordance with the Data Protection Act (1998) and the General Data Protection Regulation (GDPR). Data will not be released without your permission but may be used to verify qualifications and to prevent fraudulent activity.

**I have included with my application as applicable** (tick box and delete as appropriate):

Evidence of experience	Original/Attested Copies	<input type="checkbox"/>
Evidence of Part 1 Exempting qualification	Original/Attested Copies	<input type="checkbox"/>
Change of name document	Original/Attested Copies	<input type="checkbox"/>
Examination fee	Method of payment form	<input type="checkbox"/>

(Fee as shown on the College website: [www.rcpsg.ac.uk](http://www.rcpsg.ac.uk))

**Candidates must complete this application in full and sign the declaration below. The application must then be returned along with the examination fee and all relevant documentation to the College. Completed applications must be received by the published closing date of entry.**

**DECLARATION** (to be signed by ALL candidates)

I have read the current Regulations for this examination and understand the eligibility criteria and I now confirm that to the best of my knowledge all the information given on this form is a true statement of fact.

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(day/month/year)

**Candidate Name (Block Capitals)** \_\_\_\_\_

<b>Examination</b>	<b>Date of Exam</b>
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**Bank Draft** ☐ **Cheque** ☐ **Credit Card** ☐ **Debit Card** ☐

### Credit/Debit Card

**Card Type:** Visa ☐ MasterCard ☐ Maestro ☐ Delta ☐ JCB ☐ Visa Debit ☐

<b>Name of Cardholder as it appears on credit/debit card</b>	
<b>Billing Address of Cardholder</b>	
<b>E-mail Address of Cardholder</b>	
<b>Telephone Number of Cardholder</b>	
<b>Signature of Cardholder</b>	

**Card Number:**

**Security Code**    (last 3 numbers on signature strip)

Start Date (mm/yy)     Expiry Date (mm/yy)

Issue Number    Amount to debited from card (GBP)

The method of payment form **should be completed by all candidates and must accompany your application form to reach the College by the closing date for applications.** Failure to complete any part of this form may delay the application process and may result in you being unable to sit the examination at the requested diet.

**Any candidate withdrawing an application for admission to an examination must do so in writing.** Provided a withdrawal request is received before the application closing date, a full refund of the examination fee will be issued, less an administration fee. After the application closing date, refund of the fee will not normally be made to a candidate who withdraws or fails to attend.

## EQUAL OPPORTUNITIES MONITORING

The Royal Colleges of Physicians and Surgeons of Glasgow aim to ensure fair treatment in relation to admission and assessment of examination candidates. Completing this form will allow us to monitor our statistics and ensure that we are delivering a fair examination to all candidates.

**In line with UK legislation and good practice guidelines, we are asking all applicants to complete this section. You are not obliged to provide any of the information in this section, but if you do so, it will enable us to monitor our business processes and ensure that we provide equality of opportunity to all.**

This information will be recorded electronically with your other data in accordance with the UK Data Protection Act 2018 and the General Data Protection Regulation, but used only for monitoring our business practices.

### Gender

- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ Prefer not to say

### Ethnicity

**Choose one selection from the list below to indicate your ethnic group or background.**

#### a) White

- ☐ English/Welsh/Scottish/Northern Irish/British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Any other White background (write in)

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#### b) Mixed / Multiple Ethnic Groups

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other mixed background (write in)

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#### c) Asian or Asian British

- ☐ Bangladeshi
- ☐ Chinese
- ☐ Indian
- ☐ Pakistani
- ☐ Any other Asian background (write in)

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#### d) Black or Black British

- ☐ African
- ☐ Caribbean
- ☐ Any other Black background

#### e) Other Ethnic Group

- ☐ Arab
- ☐ Any other ethnic background (write in)

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- ☐ Prefer not to say

### ***Do you consider your first language to be English?***

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

***Do you have a disability under the terms of the Equality Act 2010? (The Equality Act defines a disabled person as someone who has a physical or mental impairment that has a substantial and long-term negative effect on your ability to do normal daily activities).***

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

### ***What is your sexual orientation?***

- ☐ Bisexual
- ☐ Heterosexual
- ☐ Lesbian or Gay
- ☐ Prefer not to say

### ***Marital Status***

- ☐ Single
- ☐ Married
- ☐ Cohabiting
- ☐ Civil partnership
- ☐ Separated/divorced
- ☐ Widowed
- ☐ Prefer not to say

### ***What is your religion or belief?***

- ☐ Buddhist
- ☐ Christian
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Other religion/belief
- ☐ No religion
- ☐ Prefer not to say