

APPLICATION FORM

Part 1 of the PLAB Test

We will use the information on this form to update, administer and maintain your record, process complaints, compile statistics, and send you relevant material. We supply data to the Department of Health, professional, educational and training bodies so that they can update their own information and compile statistics.

**GENERAL
MEDICAL
COUNCIL**

*Protecting patients,
guiding doctors*

PLEASE READ [ADVISE TO CANDIDATES](#) CAREFULLY BEFORE COMPLETING THIS FORM. THIS CAN BE ACCESSED FROM THE WEBSITE WWW.GMC-UK.ORG OR BY PHONING THE GMC ENQUIRY LINE ON +44 (0)8453 573456, OR EMAIL PLAB@GMC-UK.ORG. PLAB PART 1 TESTS CAN NOW BE BOOKED ON-LINE. PLEASE VISIT WWW.GMC-UK.ORG/REGISTER FOR DETAILS.

PLEASE COMPLETE THIS FORM IN FULL. WRITE CLEARLY AND IN CAPITALS.

PLEASE NOTE INCOMPLETE FORMS WILL DELAY ALLOCATION TO A TEST DATE

Your personal details

You must complete those sections marked*

GMC Reference Number (if known):	<input type="text"/>	
Have you made a previous application for PLAB? *	Yes [<input type="checkbox"/>]	No [<input type="checkbox"/>]
Please state the following details as they appear on your passport		
Passport number: *	<input type="text"/>	Address: * <input type="text"/>
Place of issue: *	<input type="text"/>	
Country of issue: *	<input type="text"/>	
Date of expiry: *	<input type="text"/>	
Surname: *	<input type="text"/>	Post code: <input type="text"/>
Given name: *	<input type="text"/>	Telephone: * <input type="text"/>
Other names:	<input type="text"/>	Mobile: <input type="text"/>
Title: *	<input type="text"/>	Email: <input type="text"/>
Date of birth (Day Month Year): *	<input type="text"/>	Nationality: * <input type="text"/>
Sex: *	<input type="text"/>	First language: * <input type="text"/>

Your qualifications

You must complete those sections marked*

Full Name as stated on qualification: *

Primary Medical Qualification (e.g. MB BS, MB ChB): *

University or conferring body: *

Date passed: *

Date conferred:

Country of qualification: *

Other qualifications:

Title:

Field of medicine:

Date passed:

Title:

Field of medicine:

Date passed:

IELTS results

* fields are mandatory

IELTS Test Report Form Number: *

Please complete your IELTS results

Overall Score: * []

Listening: * []

Writing: * []

Reading: * []

Speaking: * []

Date of IELTS examination (Day Month Year): *

I would like to take Part 1 of the test on one of the dates specified below:

1. Date (Day Month Year):

(Venue): *

2. Date (Day Month Year):

(Venue): *

3. Date (Day Month Year):

(Venue): *

NB: Please ensure you put three different dates. If you do not your application may be delayed.

Ethnic origin

We are committed to eliminating bias and promoting equality of opportunity, irrespective of race or ethnic background. We regularly review the ethnic background of all PLAB test candidates to make sure we are as free from bias as possible.

This information will not be given to examiners but will be used to monitor the PLAB test. It will be treated confidentially and will be published only in a form that does not allow individuals to be identified. You do not have to complete this section but you will be providing us with vital information if you do so.

Please tick the appropriate box below to indicate the ethnic group to which you belong. The list of categories has been drawn up in consultation with the Commission for Racial Equality.

Bangladeshi

Indian

Black African

Irish

Black Caribbean

Pakistani

Black Other (please specify)

White

Chinese

Other (please specify)

Character declaration

I declare that:

- The information given in this application is true and accurate.
- I understand that if a test admission letter is sent to me, I will be charged a [cancellation fee](#) if I decide to postpone or cancel my test place.

Please check that the information provided is correct. If you have given false or incorrect information, you may not be allowed to sit the test or be granted registration even if you have passed the PLAB test.

Signature of applicant

Date (Day Month Year)

If you want to take the test in the UK, send this form, and the fee of £145, to The Registration Directorate, General Medical Council, 350 Euston Road, Regent's Place, London NW1 3JN.

If you want to take the test outside the UK, send this form, and the fee of £145, to the appropriate British Council office (see [Advice to Candidates](#)).

You may pay by cheque, sterling banker's draft, money order or postal order. Whichever you choose, make it payable to The General Medical Council.