



Higher Certificate of Clinical Competence



Application for assessment/examination
at the next available date

SURNAME		DATE OF BIRTH	
FORENAME		BAA MEMBERSHIP NO.	
TITLE (please circle)	Dr / Mr / Ms / Mrs / Miss	REGISTRATION STATUS (please circle)	Registered Clinical Scientist / Registered Clinical Physiologist / Pre-registration

e-mail:	
Address	
Supervisor	e-mail:
Address (If different from candidate)	

Address for invoicing (if different from work address)

Assessment requested:

Type of module / assessment	Tick	Title of module	Syllabus used (date on pack)
Clinical Module			
Non-clinical module			
Written examination			

Confirmation that the learning outcomes have been achieved and that for clinical modules the candidate has completed the minimum clinical experience required.

Signed (Candidate)	Date
Signed (Supervisor)	Date

On completion of the assessment request form - please send directly to the examination co-ordinator at the address given on the BAA website (HTS Section). Confirmation of receipt of the form will be sent by the examination co-ordinator. Following confirmation, you will receive an invoice for the amount owed directly from the BAA office. Payment will need to be received prior to assessment of the module.

Current fees are given on the BAA website.

Please ensure all parts of this form are complete and enclosed, otherwise assessment cannot take place.

For office use only

Date received		Notes
Date assessed		
Date letter/ email sent		
Outcome	Agreed / Refer	