HKCFP Exit Examination

Practice Assessment

Pre-Exit Review of Medical Records

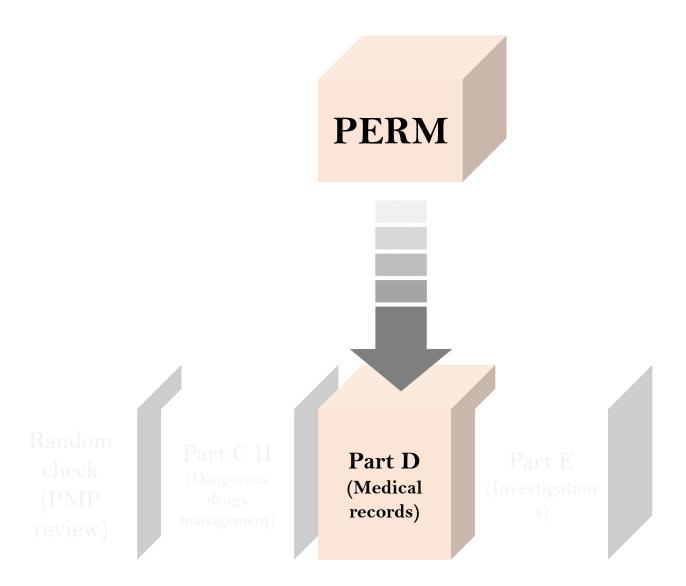# (PERM)

General Information

3 March 2023

Practice Assessment consists of 4 Parts

Random check (PMP review)

Part C II (Dangerous drugs management)

Part D (Medical records)

Part E (Investigations)

PERM

Random check (PMP review)

Part C II (Dangerous drugs management)

Part D (Medical records)

Part E (Investigations)

PERM: pre-exit review of medical records

Pre-Exit Review of Medical Records (PERM)

Candidate preparation

The Assessment

PERM and Exit Examination

What
to
prepare

What
will be
assessed

Tips on
Good practice

Consensus
on marking

Candidate preparation

- 100 medical records

- 100-case log

100 medical records

1. Collect **medical records** of **100 different patients**

   that consulted you in a **six-week period**

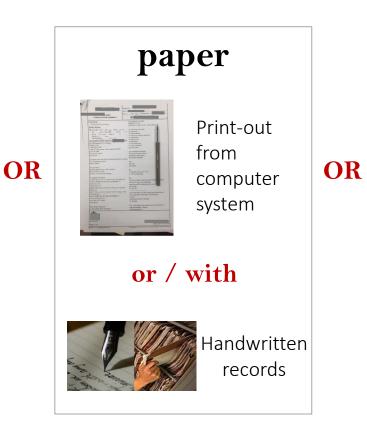   between **1ˢᵗ May to 31ˢᵗ August 2023**

Exclude:

- Medical examination , health assessment / screening

For example: the 100 Cases are collected between

- 1 May to 11 June 2023; or

- 19 June to 30 July 2023; or

- 21 July to 31 August 2023, etc.

100 medical records

2. The **format** of medical records in **PERM** can be:

on the computer screen

OR

paper

Print-out from computer system

or / with

Handwritten records

OR

A hybrid of both

However, please note

The **format** of medical records **in** **Exit Exam (PA)** :

paper

Print-out from computer system

or / with
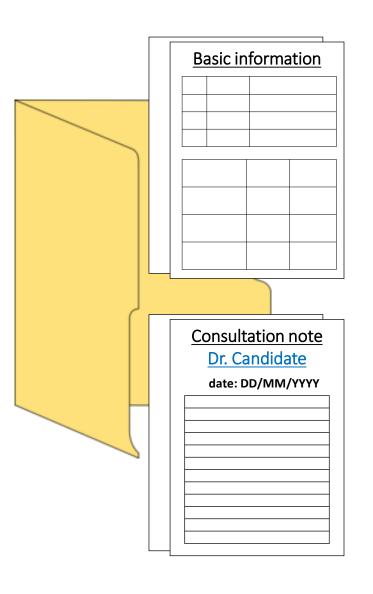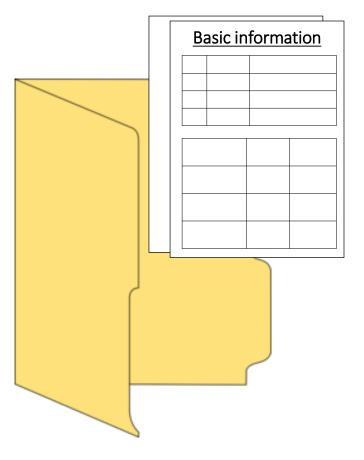

Handwritten records

AND

Readily retrievable and available upon Assessor's request

100 medical records

3. The content of each medical record for assessment should at least include:

Basic information

Consultation note
Dr. Candidate
date: DD/MM/YYYY

i. Basic information

ii. Consultation notes

100 medical records

i.   Basic information

On following areas

as appropriate and as applicable

- Allergy / Adverse drug reactions
- Current medication list
- Problem list (Current / Past health)
- Family history (with genogram as appropriate)
- Social history, occupation
- Height, weight, BMI/ growth chart, blood pressure
- Immunization
- Tobacco & alcohol use; physical activity

Please note:
It is not mandatory to have full documentation on all the areas in every record

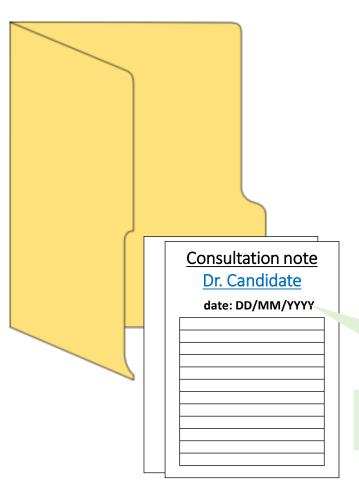# 100 medical records

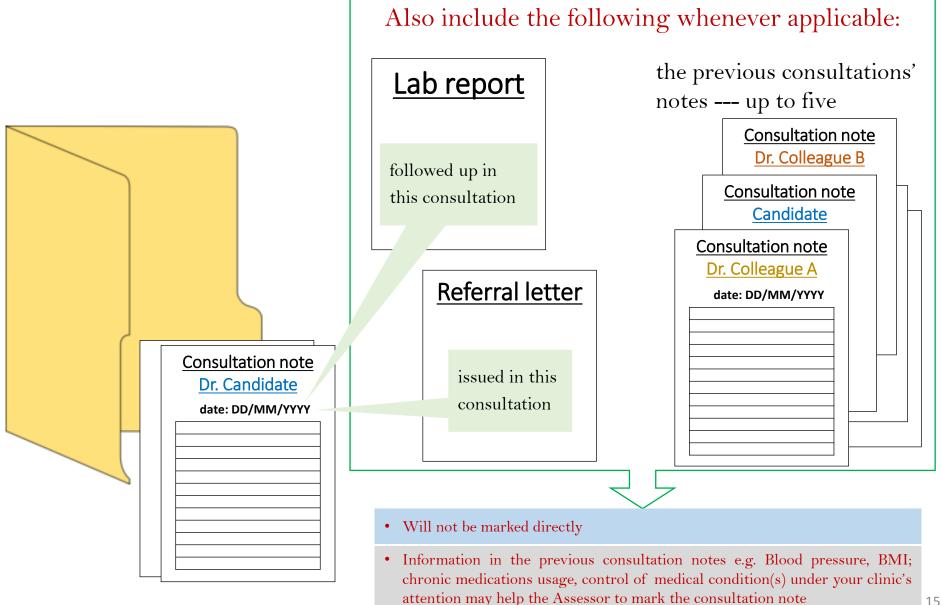## ii. Consultation notes

On following areas

as appropriate and as applicable

- Main reason(s) of consultation
- Clinical findings
- Diagnosis / working diagnosis
- Management
- Anticipatory care advice

Consultation note
Dr. Candidate
date: DD/MM/YYYY

Please note:
- **As appropriate and as applicable**
- **Not mandatory in every consultation**

Date of the consultation: to be stated in the **100-case log**

100 medical records

Also include the following whenever applicable:

Lab report

followed up in this consultation

Referral letter

issued in this consultation

the previous consultations' notes --- up to five

Consultation note
Dr. Colleague B

Consultation note
Candidate

Consultation note
Dr. Colleague A

date: DD/MM/YYYY

Consultation note
Dr. Candidate

date: DD/MM/YYYY

- Will not be marked directly

- Information in the previous consultation notes e.g. Blood pressure, BMI; chronic medications usage, control of medical condition(s) under your clinic's attention may help the Assessor to mark the consultation note

100-Case Log
(template)

A. Template for 100-Case Log

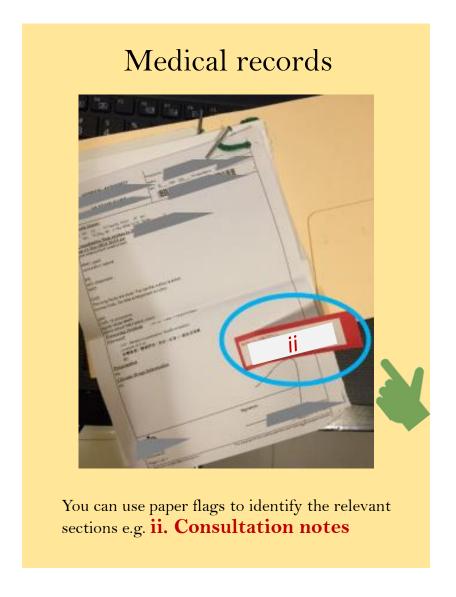| Serial no.	Patient record number	Patient initials	sex	age	diagnosis	Date of the consultation	Date of first attended the clinic
1							
2							
3							

100-Case Log

Table summary of the collected case in a standard format

Serial no.	Patient record number	Patient initials	sex	age	diagnosis	Date of the consultation	Date of first attended the clinic
1	3216	NFK	F	25	URTI	20 May 2022	18 OCT 2010
2	8839	LKF	F	46	DEPRESSION	20 May 2022	25 JUL 2011
3	292	KPW	M	87	DM, HT, HYPERLIPIDEMIA	21 May 2022	18 SEP 1999
4				1	URTI		
5				12	ALLERGIC RHINITIS		
6	4454	CHC	M	67	HT	21 May 2022	12 JAN 2011
…	…	….	…	…	…	….	….
100	2323	LKH	M	38	URTI	29 June 2022	24 OCT 2011

If the assessor choose to assess this record

This consultation notes would be selected for assessment

Confidentiality: Do not include patient's name, HKID
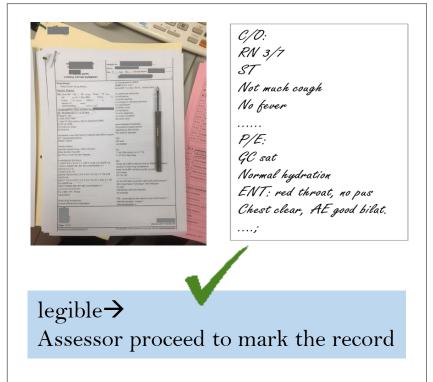
Suggestions on presenting PERM materials to assessor

100-Case Log

EXAMPLE

Medical records

You can use paper flags to identify the relevant sections e.g. **ii. Consultation notes**

Areas to be assessed

0. Legibility

C/O:
RN 3/7
ST
Not much cough
No fever
......
P/E:
GC sat
Normal hydration
ENT: red throat, no pus
Chest clear, AE good bilat.
....;

✓

legible→
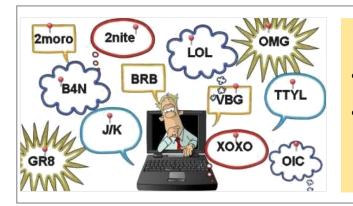Assessor proceed to mark the record

NOTE 1

✗

Illegible →
the whole case will not be marked

Use abbreviations sensibly

- Understood by most general practitioners
- Can prepare a 'reference list of abbreviations' for Assessor; but acceptance subject to the Assessor's judgment

i.   Basic information

- Allergy / Adverse drug reactions

- Current medication list — refers to the regular medications from your clinic

- Problem list (Current / Past health)

- Family history (with genogram as appropriate) — **Genogram: not mandatory in every case**

- Social history, occupation

- Height, weight, BMI/ growth chart, blood pressure

- Immunization

- Tobacco & alcohol use; physical activity

- As appropriate
- As applicable
- Dated
- Updated
- Consistent with other parts of the medical record

Please note:
It is not mandatory to have full documentation on all the areas in every medical record

i.   Basic information
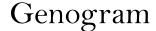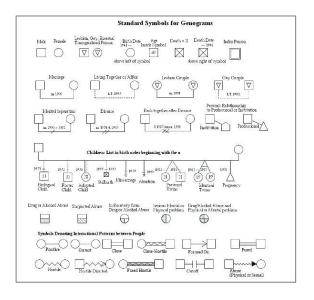
Use of templates / tables

Basic information

- Preferred
- Should have significant 'negatives' e.g. Allergy: nil known

- **As appropriate and as applicable**
- **Not mandatory to full in all the blanks on the template in every medical record**
- **Inappropriate 'blanks' on the template/ table may be regard as missing information**

i. Basic information

Genogram

Standard Symbols for Genograms

- At least (but not limited to) 2 generations
- Relevant & specific for the patient
- Show index patient
- Family members' health condition if deceased: cause & age of death
- Show members who are living together

No genogram in some cases could be acceptable, e.g.

- Communication difficulty (e.g. impaired cognition, hearing, speech, language barrier)
- Lack of appropriate informants
- Medical emergency encountered

ii.   Consultation notes

- Main reason(s) of consultation

- State **clearly in the initial part** of the consultation notes; e.g.

  - *FU DM, HT, hypothyroidism*

  - *C/O: runny nose 2/7*

- **Avoid preceded by irrelevant past information**; **the main reason(s) of the consultation** would not sink into the paragraphs of notes causing confusion / misunderstanding

- Keep any **'introductory information'** e.g. significant past / current medical information **concise and relevant**
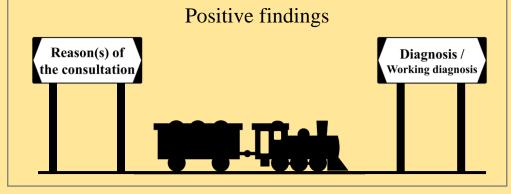
ii. Consultation notes

- Clinical findings
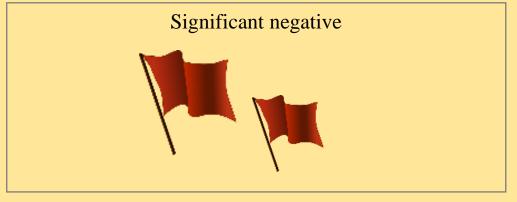
- **Group the findings** under headings e.g. history, physical exam, diagnosis / impression, management, anticipatory care (AA) etc.

C/O
Runny nose 1/7
Watery,
Mild ST,
Not much cough
No fever
TOCC –ve
………..
PE:
GC sat
Temp: ….
Hydration N
…….
Mx:
…….

FU DM , HT
Good compliance to Rx
Tolerated
No hypoglycemia
Diet: usual care; but avoiding sweety fatty foods
Ex: nil regularly
……….
PE:
GC sat
BP
Hstix 2hr pp …….
Mx:
… …. …
AA:
Discussed DEXA , patient not keen at present

ii. Consultation notes

- Clinical findings

- Record **positive** and **significant negative** clinical findings

Positive findings

Reason(s) of the consultation

Diagnosis / Working diagnosis

Significant negative

ii.   Consultation notes

- Clinical findings

- **Follow up significant issue(s) raised in previous visits as appropriate**
  e.g. overweight, smoking, elevated blood pressure

- **ICE** (idea / concern / expectation) ,
  Elaborated psycho-social history:
  o may not be necessary in straightforward episodic physical / chronic follow up cases
  o important in certain situations e.g.
     ▪ Psychological condition; e.g. insomnia, depression follow up
     ▪ Diagnostic or management challenge e.g.
        ❖ occurrence of a potentially sinister condition (e.g. suspected malignancy)
        ❖ suboptimal chronic disease control
        ❖ distressed patient / relatives
     ▪ Volunteered by the patient / relatives

ii.   Consultation notes

- Diagnosis / working diagnosis

  - **Must be stated** in the consultation note

- For straightforward episodic / regular follow up cases: state the diagnosis usually sufficient
- Status of control in chronic disease e.g.
  - *HT, stable*
  - *DM suboptimal control*
  - *lipids on statin, at target (< 2.6)*
- 'Triple diagnosis': psycho-social status as appropriate; e.g.
  - *Dementia, care-taker (wife) stress*
  - *Depression, recently employed*
- In case cannot arrive at a diagnosis, give differential diagnoses (ddx) / working diagnosis / clinical impression:
  - *Dizziness; ddx: BPPV, vestibulitis*
  - *Weight loss: bowel pathology?, hyperthyroid*
  - *LUTS: BPH, Co-existing UTI?*

  Exhaustive list of ddxs is not necessary

ii.   Consultation notes

- Management

  - Drug use or/ and non-pharmacological measures:
  - Injudicious use of drugs e.g. inappropriate use of steroids, hypnotics, will be penalized

RAPRIOP

If follow up is required:
- 'planned': the interval should be appropriate to the nature of problem(s) to be reviewed
- 'FU p.r.n.', 'open FU': give appropriate advice e.g.
  'return / seek medical attention if':
  the tongue ulcer not improve in the next 2 weeks
  rash / vesicles develop on the region you feel the pain

Referral
If you expect the patient should be seen by a designated specialist with high priority / urgent basis, consider:
- follow up / contact the patient for confirmation
- remind patient such as *return / contact clinic if not seen by Breast Clinic within three weeks*

ii. Consultation notes

- Anticipatory care advice

- Anticipatory care advice (AA) is contemplated in:
  - straightforward episodic encounter,
  - stable regular follow up chronic medical condition
- AA may not be essential in certain situations, e.g. prolonged consultations due to
  - Patient raised multiple issues
  - Presence of sophisticated psycho-social issues
  - Diagnostic difficulties
  - Management difficulties
- One AA advice in one consultation should be sufficient
- Age and gender appropriate
- Document patient's response to the AA, e.g.
  - *Discussed bone density & DEXA; patient not keen, cost concern*
  - *Flu-shot today at clinic*
  - *PAP smear: due next year in FPA*

The Assessment

- Choose ten medical records from the 100-case log
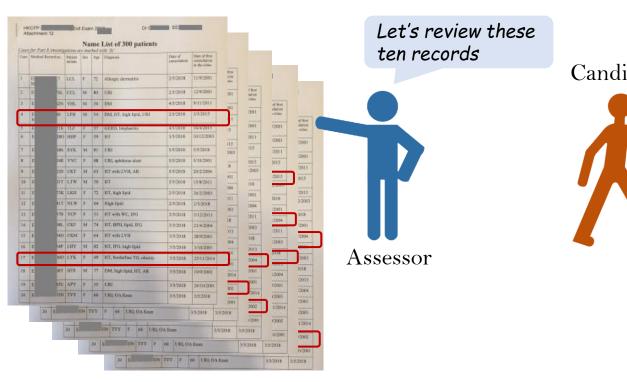
- Mark the ten records

- Feedback to the candidate

Who can be PERM Assessor?

Candidate's Clinical Supervisor in Higher FM Training

OR

PA Examiner
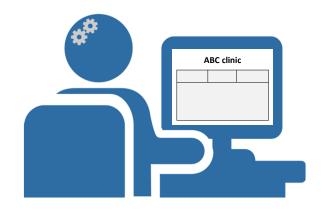
Choose ten medical records from the 100-case log

Explain the layout of the medical records to Assessor
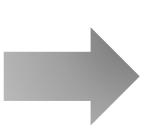
Assessor marks the ten medical records

AND /OR

PERM Assessment Form

PERM Assessment Form

Enter the serial no.

Enter the serial numbers of the ten records chosen

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8	9	10
	9	26	35	41	51	63	72	78	84	100
0. Legibility										

Let's review these ten records

Assessor

Legibility

PERM Assessment Form

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8	9	10
	9	26	35	41	51	63	72	78	84	100
0. Legibility	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗

Check legibility of each records

legible→
Assessor proceed to mark the record

Illegible →
the whole case would not be marked

Basic information

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8	9	10
	9	26	35	41	51	63	72	78	84	100

i. Basic Information										

- Allergy / Adverse drug reactions
- Current medication list
- Problem list (Current / Past health)
- Family history (with genogram as appropriate)

- Social history, occupation
- Height, weight, BMI/ growth chart; blood pressure
- Immunization
- Tobacco & alcohol use; physical activity

Grade (please circle one)

A	Very good to Outstanding, mastery of most components and capability
C	Satisfactory to good in most components
E	Need to overcome some omissions / defects that have impact on patient care
N	Need attention to avoid unsafe practice

Basic information

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8	9	10
	9	26	35	41	51	63	72	78	84	100

i. **Basic Information**										

- Allergy / Adverse drug reactions
- Current medication list
- Problem list (Current / Past health)
- Family history (with genogram as appropriate)

- Social history, occupation
- Height, weight, BMI/ growth chart; blood pressure
- Immunization
- Tobacco & alcohol use; physical activity

1. Assess the basic information of each record
2. Use the grid to jot notes or the key impression

Basic information

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8	9	10
	9	26	35	41	51	63	72	78	84	100

i. Basic Information	✓✓	✓	✗	✓	✓	✓	✓✓	✗	*No growth chart*	✓

- Allergy / Adverse drug reactions
- Current medication list
- Problem list (Current / Past health)
- Family history (with genogram as appropriate)

- Social history, occupation
- Height, weight, BMI/ growth chart; blood pressure
- Immunization
- Tobacco & alcohol use; physical activity

- No rules in using the grid
- Help to recall when drafting feedback and grading the global performance
- May use other symbols preferred by assessor e.g. ++ , + , +/- , - etc.

Basic information

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8	9	10
	9	26	35	41	51	63	72	78	84	100

i. Basic Information	✓✓	✓	✗	✓	✓	✓	✓✓	✗	*No growth chart*	✓

Grade the global performance

- Allergy / Adverse drug reactions
- Current medication list
- Problem list (Current / Past health)
- Family history (with genogram as appropriate)

- Social history, occupation
- Height, weight, BMI/ growth chart; blood pressure
- Immunization
- Tobacco & alcohol use; physical activity

Grade (please circle one)

A	Very good to Outstanding, mastery of most components and capability
(C)	Satisfactory to good in most components
E	Need to overcome some omissions / defects that have impact on patient care
N	Need attention to avoid unsafe practice

Comparison of PERM Grading and PA rating

Grading in PERM		Rating in Part D, PA / Exit Exam	
A	Very good to Outstanding, mastery of most components and capability	8.5 or above	Consistently demonstrates outstanding performance in all components; criterion performance. (outstanding)
		8	Consistently demonstrates mastery of most components and capability in all. (Very Good)
		7.5	
C	Satisfactory to good in most components	7	Consistently demonstrates capability in most components to a professional standard. (Average to good) *(minor omissions / defects that can be tolerated)*
		6.5	
E	Need to overcome some omissions / defects that have impact on patient care	6	Demonstrates capability in some components to a satisfactory standard; but with omissions and/ or defects in other components that have impact on patient care. *(such omissions/ defects were seen in two or more of the Cases assessed)*
		5.5	
		5	Demonstrates inadequacies in several components with major omissions or defects.
		4.5	
N	Need attention to avoid unsafe practice	4 or below	Demonstrates serious defects; clearly unacceptable standard overall.

Consultation Notes

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8	9	10
	9	26	35	41	51	63	72	78	84	100

ii. Consultation notes

	1									
Main reason(s) of consultation	✓									
Clinical findings	✓✓									
Diagnosis/ Working diagnosis	✓									
Management	✓✗									
Anticipatory care advice	✓									

Use the grid to jot the key impression of each case

e.g.
- for good performance: ✓✓
- for satisfactory performance: ✓
- for omissions / defects: ✗
- for issues with safety concerns: ✗
- Not applicable: NA

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Consultation Notes

ii. Consultation notes										
Main reason(s) of consultation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clinical findings	✓✓	✓	✓	✓✓	✓	✓	✓✓	✓	✓	✓✗
Diagnosis/ Working diagnosis	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓
Management	✗✓	✓	✓	✓	✗✓	✓	✓	✓	✓✓	✓
Anticipatory care advice	✓	NA	✓	✓	✓	✓	✓	✓	✓	NA

Grade (please circle one) — Grade the global performance

A	Very good to Outstanding, mastery of most components and capability
(C)	Satisfactory to good in most components
E	Need to overcome some omissions / defects that have impact on patient care
N	Need attention to avoid unsafe practice

Overall performance

Overall performance	
Grade (please circle one)	
A	Very good to Outstanding, mastery of most components and capability
C	Satisfactory to good in most components
E	Need to overcome some omissions / defects that have impact on patient care
N	Need attention to avoid unsafe practice

Please note

Grade (please circle one)	
A	Very good to Outstanding, mastery of most components and capability
C	Satisfactory to good in most components
E	Need to overcome some omissions / defects that have impact on patient care
N	Need attention to avoid unsafe practice

The PERM Report **will be rejected** by Specialty Board

Feedback to the candidate

Comment on
- Global performance
- Individual cases
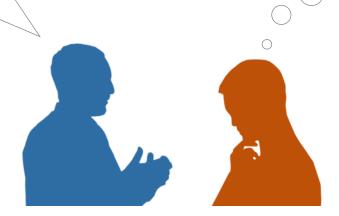
The fact you noted

Your opinion as appropriate

Consolidate on:
- Good performance

make prioritized changes on:
- Area(s) need improvement
- Area(s) need attention
- Undesirable practice

Preferably to be conducted at earliest convenience after the marking
- Still having fresh memories on the cases
- Allow sufficient time for the candidate to consolidate and change

Feedback to the candidate

Assessor documents the Feedback

Summary of the feedback given to the candidate

Feedback:

i.   Basic Information

_____

_____

_____

_____

_____

_____

_____

ii.   Consultation notes

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Overall / other comments

_____

_____

_____

_____

_____

_____

Some examples

- *Case 64: Basic information (HAFM) form show "no HT", but in fact patient was HT on atenolol*
- *Case 100: No growth chart (age 3); irrelevant social history: non-smoker / drinker*

Feedback to the candidate
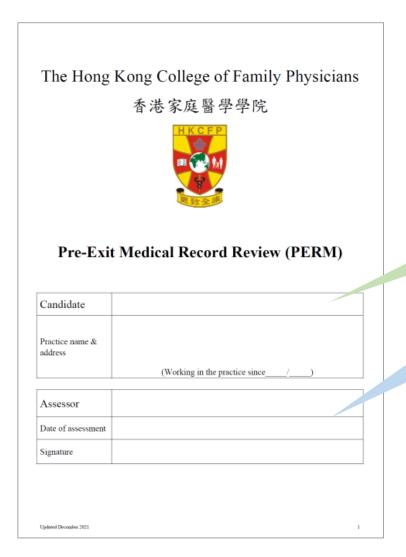
Assessor documents the Feedback

Please tick the area(s) need attention / improvement according to the overall performance:

Overall performance on Basic Information: area(s) need attention / improvement	If applicable, please ✓; higher priority ✓✓, etc.	remarks
• Insufficient positive / significant negative information		
• Inaccurate / inconsistent with other part(s) of the record		
• Information not updated		
• Documentation: length not appropriate OR unclear		
• Others:		

Overall performance on Consultation Notes: area(s) need attention / improvement	If applicable, please ✓; higher priority ✓✓, etc.	remarks
• Main reason(s) of consultation unclear		
• Insufficient documentation of clinical findings		
• Diagnosis/ Working diagnosis unclear		
• Suboptimal management	✓	
• Lack of / inappropriate anticipatory care advice		
• Documentation: length not appropriate OR unclear		
• Others:		

Completing PERM Report

Pre-Exit Medical Record Review (PERM)

Candidate's information

Assessor's signature

PERM Report

The ten medical records assessed in PERM must be kept till 31st March next year

These records may be reviewed by delegates of Specialty Board for:

- suspected misconduct in PERM when necessary; OR
- quality assurance as agreed by the candidates and assessors
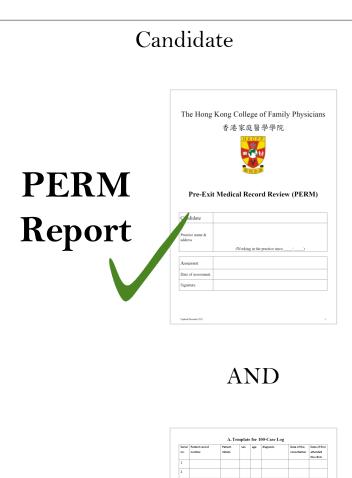
Some observations, comments and recommendations from previous PA (Part D Medical Records)

issue noted	Comments / recommendations
Submitted duplicate cases in the case-log	• To be avoided • In Exit Exam: risk of penalty & disqualifications
Housewife; given sick leave for IOD	
Tramadol and pholcodine; both opioid types, risk of respiratory suppression	
F/61 FU for neck pain, numbness UL The consultation notes (done in 9/17) typed: MRI neck (9/17): C3/4; C4/5; C5/6; C6/7 mild spinal stenosis with compressing cord…C3/4 mild increase T2 intensity suggestive of early compressive myelopathy. Ortho pending 12/ 2018 -- should attempt to advance the orthopedic appointment Mx: Referred to Physiotherapy -- potential unsafe Mx	
HT newly on drug; no regular FU was arranged, instead advised patient to self book IVAS. Also there is a DM RAMP podiatrist appointment for patient in the record, it is not sure if patient in having DM or not.	
"Other allergy" section left blank on the basic information templates	• Enter 'nil' , 'nil known'
ENT referral made; but not a single word on ENT symptoms found in the record	
Topical urea cream prescribed; indication not found in record	

issue noted	Comments / recommendations
• Case A - Syncope 2nd time with few months should need further work up rather than just treatment GI symptoms. DDx may include TIA epilepsy • Case B – sub-mandibular mass may need further work up. e.g. sputum culture, imaging • Overall impression: little attempt to arrive provision dx / ddx; problems are then mostly referred out. Can discuss more with patient and suggest more for options	
Can consider other DDx in kids with prolonged cough e.g. allergic rhinitis; not followed up	
Genogram: there was no age and health information for those alive; although age and cause of death of the deceased family members are recorded	• In case of time constraint, focus on information of closely blood-related, spouse, living together (i.e. members surrounding the patient). Put down the significant positives, 'in good health', etc.
Patient has ECG; routine care? or ordered for any symptoms? Not documented in history and the referral letter.	
Why 10 year old child epistaxis given neomycin cream?	

issue noted	Comments / recommendations
Fasting Hstix 8.3 – 10.4, A1c 8.5%, hx too brief, better to have more hx on lifestyle and any symptoms of poor DM control. Mx just stepped up metformin from 500 mg BD to 750 mg BD, not likely to bring significant improvement	
No immunization record for child cases	

PERM
and
Exit Exam

Candidate

PERM Report ✓

The Hong Kong College of Family Physicians
香港家庭醫學院

Pre-Exit Medical Record Review (PERM)

Candidate	
Practice name & address	
	(Working in the practice since _____/_____)
Assessor	
Date of assessment	
Signature	

AND

100-case log ✓

A. Template for 100-Case Log

Serial no.	Patient record number	Patient initials	sex	age	diagnosis	Date of the consultation	Date of first attended the clinic
1							
2							
3							

To be submitted with

the Exit Examination Application

(deadline: 1st working day of November)

Candidate

PERM Report ✓

AND

100-case log ✓
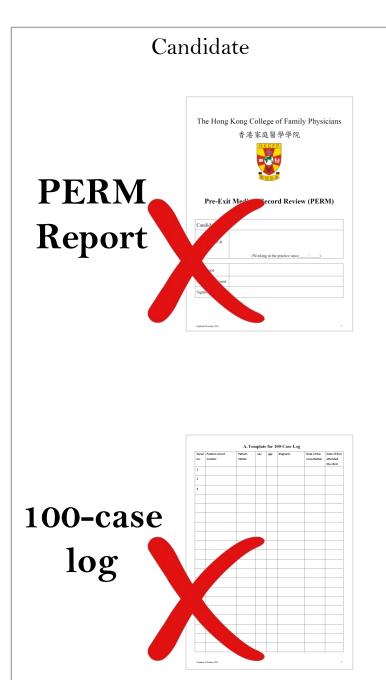
Collect **100 medical records for Part D** (Medical Record) and separately, **10 medical records for Part E** (Investigations) in the usual six-week case collection period (usually from middle of Sep to end of Oct) for Exit Examination

Please refer to the Pre-Exit Examination Workshop for candidates in August every year

Candidate

**PERM
Report** ✗

The Hong Kong College of Family Physicians
香港家庭醫學學院

Pre-Exit Medical Record Review (PERM)

**100-case
log** ✗

A. Template for 100-Case Log

Same as the requirement of 2022 Exit Examination

Collect **300 medical records for Part D** (Medical Record) in the usual six-week case collection period (usually from middle of Sep to end of Oct) for Exit Examination

As a transitional arrangement; in about 2 years' time PERM will be mandatory

Process of PA

1. **Prepare for the examination**

2. Submit required PA Document at Exam Application

3. Examiners will visit the candidate on a designated **exam date**

   to conduct PA –which consist of:

   Random check (on PMP)

   Part CII (Dangerous drugs management)

   Part D (Medical records)
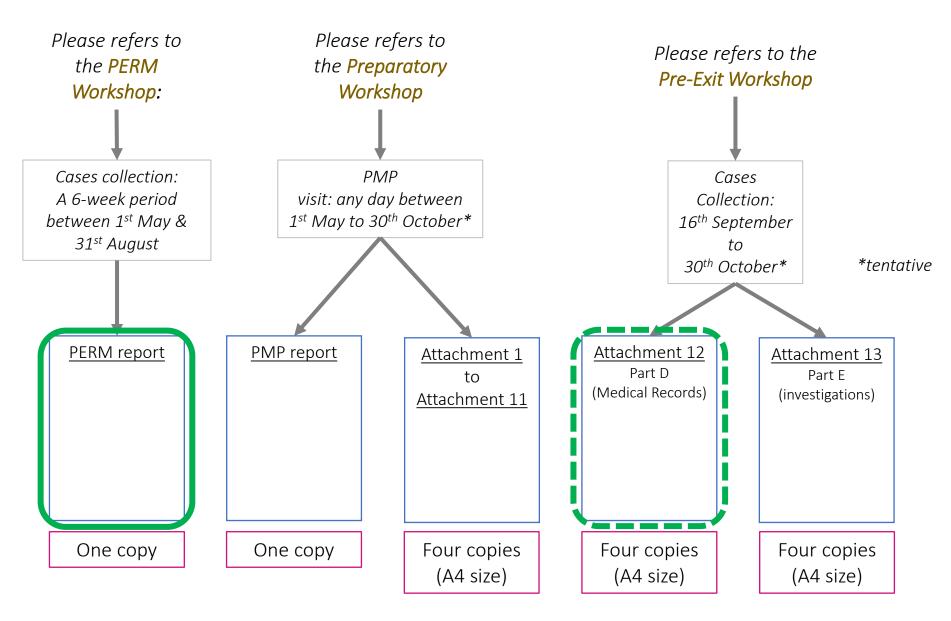
   Part E (Investigations)

4. Results announcement

5. Post Examination evaluation

PA Document

Please refers to the **PERM Workshop**:

Please refers to the **Preparatory Workshop**

Please refers to the **Pre-Exit Workshop**

Cases collection:
A 6-week period between 1st May & 31st August

PMP
visit: any day between 1st May to 30th October*

Cases Collection:
16th September to 30th October*

*tentative

PERM report

PMP report

Attachment 1 to Attachment 11

Attachment 12
Part D
(Medical Records)

Attachment 13
Part E
(investigations)

One copy

One copy

Four copies
(A4 size)

Four copies
(A4 size)

Four copies
(A4 size)

Part D: timeline

April	
May	**Pre-Exit Review of Medical Records (PERM) (Session I)**
June	
July	
August	
September	**Part D Case collection (Session II)**
October	
November	Exit Examination starts
December	

- **100 cases in 6 weeks within May – August**
- Assessor (e.g. Trainer) mark 10 cases
- Feedback must be given to candidate

- **100 cases in 6 weeks**
- Otherwise the same as current format

Prepaing PA for Exit Examination

PA Important dates				
2023 May	PMP Report Attachment 1 to 11	PERM		
June				1 May to 31 August
July				1 May to 31 Oct , 2023 (tentative)
August				
September				
October		Cases collection Attachment 12, 13		16 Sep to 31 Oct, 2023 (tentative)
November		Exam application deadline		1 Nov , 2023 (tentative)
2024 December	2022 Exit Exam Period A			1 Dec, 2021 to 31 Jan, 2022; *no exam on*
January				
February	2022 Exit Exam Period B			1 Feb to 31 Mar, 2022; *no exam on*
March				
April	Results announcement			TBC

Exit Examination

	PA Important dates		
2023			
May	PMP Report Attachment 1 to 11	PERM	1 May to 31 August
June			
July			1 May to 31 Oct , 2021
August			
September		Cases collection Attachment 12, 13	
October			20 Sep to 31 Oct, 2021
November		Exam application deadline	1 Nov , 2021
2024			
December	2024 Exit Exam Period A		1 Dec, 2022 to 31 Jan, 2024 (tentative)
January			
February	2024 Exit Exam Period B		1 Feb to 31 Mar, 2024 (tentative)
March			
April	← Results announcement		TBC

Enquiry

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