



Pupil's Name									
School Name									

DATE OF TEST		
Day	Month	Year

UNIQUE PUPIL NUMBER									

SCHOOL NUMBER					

DATE OF BIRTH		
Day	Month	Year

Please mark boxes with a thin horizontal line like this

SAMPLE PRACTICE TEST

1	2	3	4	5	6	7	8	9
A <input type="checkbox"/>	A <input type="checkbox"/>	A <input type="checkbox"/>	A <input type="checkbox"/>	A <input type="checkbox"/>	A <input type="checkbox"/>	A <input type="checkbox"/>	A <input type="checkbox"/>	A <input type="checkbox"/>
B <input type="checkbox"/>	B <input type="checkbox"/>	B <input type="checkbox"/>	B <input type="checkbox"/>	B <input type="checkbox"/>	B <input type="checkbox"/>	B <input type="checkbox"/>	B <input type="checkbox"/>	B <input type="checkbox"/>
C <input checked="" type="checkbox"/>	C <input type="checkbox"/>	C <input type="checkbox"/>	C <input type="checkbox"/>	C <input type="checkbox"/>	C <input type="checkbox"/>	C <input type="checkbox"/>	C <input type="checkbox"/>	C <input type="checkbox"/>
D <input type="checkbox"/>	D <input type="checkbox"/>	D <input type="checkbox"/>	D <input type="checkbox"/>	D <input type="checkbox"/>	D <input type="checkbox"/>	D <input type="checkbox"/>	D <input type="checkbox"/>	D <input type="checkbox"/>
E <input type="checkbox"/>	E <input type="checkbox"/>	E <input type="checkbox"/>	E <input type="checkbox"/>	E <input type="checkbox"/>	E <input type="checkbox"/>	E <input type="checkbox"/>	E <input type="checkbox"/>	E <input type="checkbox"/>

SAMPLE MAIN TEST

1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30
31	32	33	34	35	36	37	38	39	40
41	42	43	44	45					

FOR INFORMATION ONLY
SAMPLE NOT TO BE USED

