The ultimate guide to the OET Writing sub-test

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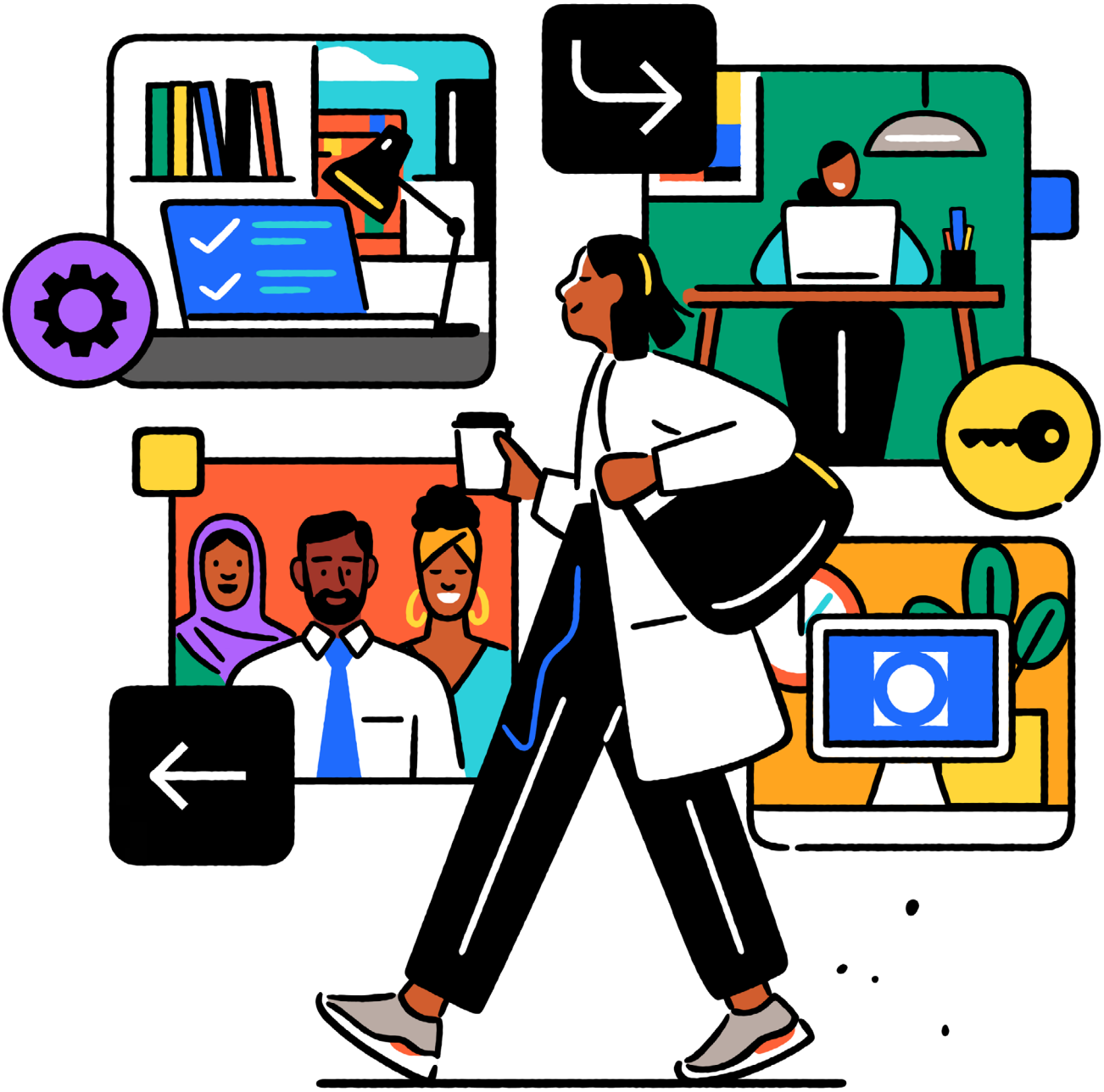
Hello

What's in this guide



Welcome to the Ultimate Guide to Writing!

We've created this guide to provide you everything you need to know about our Writing sub-test.

In this guide, you can learn about the writing skills you will need to succeed, and how to improve them.

We'll also deep dive on each of the assessment criteria we use to score your Writing sub-test.

These criteria include:

- 01. Purpose
- 02. Content
- 03. Conciseness & Clarity
- 04. Genre & Style
- 05. Organisation & Layout
- 06. Language

How the score works

Each of these criteria are assigned a score from 0 to 7, except for Purpose, which is given a score of 0 to 3. Test-takers securing grade B will have achieved scores of 2 out of 3 for Purpose and 5 out of 7 for the remaining criteria.

01. Writing with purpose

What is "Purpose", and how do you write with purpose? Purpose is quite simply the 'reason for writing' or 'why you are writing', and it is the first of six assessment criteria for our Writing sub-test. Importantly, purpose must be clear to the reader and personalised to the situation.

In Chapter One we will explain:

- The two parts of purpose
- How to identify and understand purpose
- How to show purpose in your writing

Understanding what we mean by purpose and how we expect you to demonstrate it in in your writing is critical to getting the score you want, so let's take a close look to the two parts of purpose.

What are the two parts of purpose?

Part 1: "Immediately apparent": The first part of purpose is making the reason for the letter "immediately apparent". In other words, making it clear why you are writing the letter and why the reader should read it.

By starting your letter with a clear explanation of its purpose, the reader does not have to spend time searching for what is important. This is important for healthcare professionals who often are time poor.

Part 2: "Sufficiently expanding": **The second part of purpose is "sufficiently expanding" the reason for your letter. To effectively give the right kind of care to patients, healthcare professionals need more information than just the high-level overview outlined in the first paragraph. That means you should expand on this overview at the end of the letter by including additional relevant details about the reason for writing.**

These are some helpful questions to ask yourself to ensure you have addressed both parts of purpose:

IMMEDIATELY APPARENT	SUFFICIENTLY EXPANDING
Why are you writing the letter?	Will the reader understand the situation?
Why should the letter be read?	Are your requests obvious to find?
Does the letter start with a clear explanation?	Does the letter provide more detail than your opening explanation?

Part 1: How do you identify the purpose, and immediately establish it in your letter?

How do you make the purpose immediately apparent in your letter? You will be writing about a unique patient who will have a unique set of healthcare needs, which means the letter you write will also have a unique purpose.

In most cases, the Writing task will clearly state what your letter's purpose is. However, if the Writing task does not have all the information you need, you should be able to find the rest of the information in the final section of the case notes.

Let us look at some examples that help you find the purpose of your letter:

Example 1

In this example, you can see this is a referral letter about further management of Mrs Sharma's sugar levels:

Writing task: Using the information in the case notes, write a letter of referral to Dr Smith, an endocrinologist at City Hospital, for further management of Mrs Sharma's sugar levels. Address the letter to Dr Lisa Smith, Endocrinologist, City Hospital, Newtown.

And here's an example of what your letter's introductory sentence could include to establish the purpose of the letter:

- *Thank you for seeing Mrs Priya Sharma, a type 2 diabetic, for further management of her blood sugar levels.*

Example 2

In this example, the Writing task tells you that this is a discharge letter about Mr Spencer's recent treatment history:

Writing task: Using the information given in the case notes, write a letter to the Occupational Therapist at the Oldmeadows Extended Care Centre, 13 River Street, Oldmeadows, where Mr Spencer is to be discharged, detailing his treatment to date and other information the therapist may need.

And here's an example of what your letter's introductory sentence could include to establish the purpose of the letter:

- *Mr Spencer has been a patient at this hospital for the past five weeks and will be discharged tomorrow. He requires your ongoing support and treatment during his rehabilitation.*

Identifying purpose in the case notes

If the Writing task has not given you all the information you need to understand the type of letter or the main topic, you can usually find it in the final section of the case notes (just above the Writing task).

Example 3

In this example – a letter of transfer requesting ongoing monitoring for this patient – the Writing task includes the purpose of the letter, but it does not include the type of letter. However, the type of letter is included in the case notes just above the Writing task.

Writing task: Using the information given in the case notes, write a letter to the Community Health Nurse in Centreville, outlining the patient's history and requesting ongoing monitoring. Address the letter to the Community Health Nurse, Eastern Community Health Centre, 456 East Street, Centreville.

Case notes: Letter to transfer the Pt to the care of the community health nurse in Centreville, where the Pt is moving to live with his daughter.

And here's an example of what your letter's introductory sentence could include to establish the purpose of the letter:

- Thank you for accepting Mr Dunbar into your care for the regular monitoring of his diabetes and encouragement to comply with his medication and dietary regimens

Establishing purpose at the start of your letter

Each of these three examples has a different purpose, which you must demonstrate at the beginning of your letter. As you can see from the example introductory sentences we've provided with each task example, each is clearly personalised to the patient's situation and uses appropriate language to explain the reason for writing.

TIP

Using the right verbs

Many candidates start their letters with 'I am writing to refer...'. Sometimes, this is appropriate, but not all tasks ask you to write a referral letter.

Depending on the type of letter you are asked to write, there are other verbs which are equally or more appropriate.

Examples of these other verbs include:

- Transfer
- Discharge
- Update
- Recommend
- See
- Accept
- Request
- Provide

Part 2: Expanding on your purpose with the right details

The second part of Purpose is to sufficiently expand the reason for writing at the end of the letter and with more details.

When explaining the reason for writing the letter, it is normal to do this at a high level. For example:

- Further management of her blood sugar levels OR ongoing support and treatment OR regular monitoring of his diabetes.

The reader is clear about the situation from this high-level explanation, but they will need more detail to continue caring for the patient adequately. This detail should be covered in the last paragraph.

Expanding the purpose includes providing details such as how often the reader should interact with the patient, what specific activities they should support the patient with, etc.

Here are three examples of sentences that expand on the initial reason for writing:

Example 1

Her non-fasting blood sugars are 7–8mmol/L, but her fasting blood sugar levels are usually in the 16+ range, which is high. Therefore, I am referring her to you for your specialist advice.

Example 2

Prior to this injury, he received home help for all house cleaning tasks and was independent in all personal care and community tasks. He is keen to return home where he lives alone and maintain his independence.

Example 3

He was diagnosed with atrial fibrillation on the same admission and was subsequently prescribed warfarin and sotalol. His hypertension is controlled by Ramipril. As with his other medication, Mr Dunbar is intermittent in his compliance.

Importantly, notice that all three examples are personalised to the situation and use language appropriate to describe it. To achieve full marks in Purpose, you need to be prepared to be flexible in your writing and not rely on pre-learned phrases and sentences.

You can do this by using the case notes to help you to write something personalised and meaningful to the reader, and ensure you achieve full marks for Purpose.

02. Choosing the right content

Content is the second criterion used to score your performance in the Writing sub-test. It covers what you put into your letter and how you refer to the case notes.

In Chapter Two, we will look at:

- The two different parts of Content
- How to choose which content to use
- How to represent the case notes accurately

What do we mean by Content?

In the Writing sub-test, you will be asked to write a letter. Whether this is a referral, discharge, or other type of letter, you need to be sure that its content provides the reader with all the information they need to continue care of the patient.

All the content you need can be found in the case notes. However, not all the case notes will be relevant to the letter.

You will need to decide which information the reader needs, while accurately representing the case notes you pull the content from.

How to choose which content to use

The letter you write should provide the reader with all the information they need to continue caring for the patient and complete any requests you make of them. How you select this information depends on a couple of questions:

- **Is there any existing professional relationship between the patient and the reader?**
- **What aspect of the patient's care will the reader be involved with?**

When reading the case notes, you should keep these questions in mind when you decide what you'll need to include. Keep an eye out for information that you think is new to the reader and directly supports their appropriate care of the patient.

Consider this example:

A hospital occupational therapist writes a letter discharging patient Jack Spencer to the occupational therapist at the Care Centre where he will receive rehabilitation.

In this example, the reader and the patient do not have an existing professional relationship so the letter will need to include information about the patient's current abilities and inabilities for the reader to get a clear understanding. Although the case notes provide details of the patient's children, grandchildren, profession and financial status, these details will not be needed for the reader because they will not impact the care they provide.

Consider a slightly different scenario:

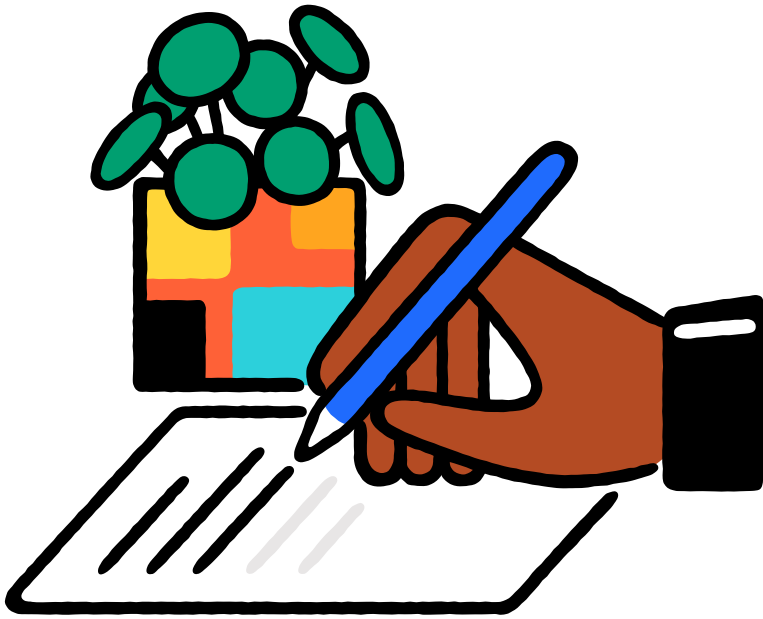
The hospital occupational therapist writes a letter to the patient's regular GP to update them on their progress.

In this example, you would need to provide different information. While the patient's social history is still not necessary to include, the details you'll need to provide about the patient's current abilities and inabilities would be different. Your letter would need to provide an update about how these have changed since the GP last saw the patient, rather than presented as new information.

In both instances, the reader should have by the end of the letter:

- a clear understanding of the situation
- no more questions about further care.

If they do have any questions, then you have not included enough information and they will not have a clear understanding of the situation.



How to accurately represent the case notes

The second key part of Content is accurately representing the case notes. This is important to ensure that the reader has a clear understanding of the situation.

During the Writing sub-test, you will summarise, or paraphrase parts of the case notes you think are relevant and important to the reader. However, it is important to represent the case notes accurately by not changing the meaning of the information. During the process of paraphrasing, you can affect accuracy by:

- Not matching the exact meaning of words in the case notes with another word
- Altering the timeframe of the situation by changing the tense used

Let us look at three examples to better understand what we mean by this:

Example 1

Case notes	Letter
Pt moving to Centreville to live with daughter & her husband.	Mr Dunbar is relocating to Centreville to be nearer his daughter and son-in-law.

While the sentence is grammatically accurate, it is an inaccurate representation of the patient's living arrangements.

Specifically, the phrases 'living near his daughter' and 'with his daughter' are very different and would impact the reader's understanding of the situation.

Example 2

Case notes

Atorvastatin (Lipitor) 20mg 1 mane added Glipizide 5mg 2 mane

Letter

Glipizade5mg taken every morning, will be added to the Atorvastatin, 20mg also taken in the morning.

The sentence is grammatically accurate, but the use of 'will be' suggests the addition will take place in the future. The sentence then provides the reader with incorrect information about the patient's medications.

Example 3

Case notes

Under surgeon's recommendation: Pt not to mobilise L arm until last wk when plaster removed.

Letter

Mr Spencer has been resuming use of his left arm since last week following the surgeon's recommendations.

As with the other examples, the sentence is grammatically accurate but fails to say that the patient's cast has been removed. Not only will this impact the continued care of the patient, it also does not give the reader an accurate description of the situation.

TIP

Keep the reader in mind!

To get full marks in Content, we encourage you to keep the reader in mind when choosing the information to add to your letter.

A good tip is to finish writing your letter with a few minutes to spare. This should give you enough time to read through your letter as the reader and ask the following questions:

- How would the reader feel at the end?
- Will the reader know what they need to do to continue care?
- Do they have the right information to action this?
- Are the facts correct?
- Have you represented the information using accurate grammar and vocabulary?

If you can answer yes to all these, you're well on your way to scoring high on Content.

03. Writing with conciseness and clarity

Conciseness and Clarity is the third criterion used to score your letter. We tend to pair the Content and Conciseness & Clarity criteria together because many of the skills, strategies and questions you apply are similar.

In Chapter Three, we will look at:

- Whether you have included unnecessary information
- How clearly you have summarised the case notes
- How clearly this summary is communicated to the reader.

Content is the criterion that assesses the information you have included in your letter; Conciseness and Clarity assesses the information you have omitted from your letter.

Confused?! Are you thinking: 'How can I be assessed on something that isn't there?'

If you do not leave out the irrelevant information from the case notes in your letter, then it can be difficult for the reader to find the important information, and they may end up misunderstanding what is required.

What to consider about leaving out irrelevant information

When it comes to deciding what is and what is not relevant, test takers tend to make three mistakes:

1.

Including information not needed for care: Including information the reader already knows or is outside the scope of their care of the patient

2.

Including too much historical detail: Providing too much background or historical detail to the current situation

3.

Not grouping similar information: Making your reader have to re-read your letter because similar information is not grouped together

Mistake 1: Including information not needed for care

Mrs Sharma's case notes cover six visits to her GP over a two-month period.

The first visit mentions this detail:

29/12/18

Discussion:
Concerned that her glucose levels are not well enough controlled – checks levels often (worried?). Attends health centre – feels not taking her concerns seriously.

The Writing task is to write a letter referring the patient to the endocrinologist. We can break this case note into what is, and what is not, relevant to the endocrinologist.

Relevant: Mrs Sharma is concerned that her glucose levels were not well controlled causing her to present on the 29 December

Not relevant: Mrs Sharma felt the health centre was not taking her concerns seriously.

Mrs Sharma's feelings on the health centre are outside of the endocrinologist's role. It does not have any impact on the assessment or treatment they will provide her.

A good summary of this case note would be:

She initially presented on 29/12/18 concerned that her blood sugar levels were no longer well controlled.

Mistake 2: Including too much historical detail

Avoiding unnecessary or repeated information is also an important part of this criterion. In many sets of case notes, multiple visits to or by the patient will be reported.

Some of the information in the earlier visits will have been superseded by how the patient's condition progressed. That means it's important to summarise the information to only include the details which remain relevant.

Mr Spencer's case notes cover his medical presentation:

Case notes: Admitted to hospital with L fractured humerus & olecranon process following fall at home. Surgery completed on olecranon process, screw inserted 4 wks ago.

Relevant: Mr Spencer's injuries were a left fractured humerus & olecranon process

Not relevant: The type of surgery.

The OT needs to know what injuries the patient sustained because it will help them correctly care for Mr Spencer. However, details of the surgery are not relevant as they will not impact the type of care provided post-discharge.

An example of a clear summary is:

Mr Spencer had a fall at his home and sustained a fracture to the left humerus and olecranon process. Surgery was completed four weeks ago.

Mistake 3: Not grouping similar information

The final element of this criterion is to group similar information together for the reader.

Grouping information will help your summary be quick and easy to read, ensuring your reader does not have to re-read the letter to understand it.

For example, patient Mr Dunbar's case notes record he is non-compliant with his diet and medication and that this is discussed with him on three separate visits including:

March 2018

Non-compliant with diet. Non-compliant with medication. Blames poor memory

October 2018

Resumed medications but still only taking intermittently. Again provided education re importance of adherence to drug regimen

The task is to transfer the patient into the care of the Community Nurse in the area where he will be moving to. The Community Nurse is requested to provide ongoing monitoring.

Relevant: Mr Dunbar's medication and diet compliance need monitoring

Not relevant: The frequency or specific dates when the patient has been recorded as non-compliant.

A good summary of these case notes would be:

He has not been compliant with his diet or medication regimen, reporting poor memory as the primary cause of his neglect.

TIP

To score high in the OET Writing sub-test, you need to choose only the relevant information from the case notes, while also leaving out irrelevant information.

The best way to do this is to avoid information that:

- is outside the scope of the reader's role
- focuses too heavily on the patient's history or background
- not grouping similar information.

If you avoid these mistakes and follow the guide for Content, you are well on your way to scoring high in the Writing sub-test.

04. The genre and style of your letter

Genre and Style is the fourth criterion used to assess your writing and looks at whether your writing aligns with the reader's knowledge and expertise.

In Chapter Four, we will explain:

- What formal writing is
- How to use the right level of formality and tone for your reader
- How your grammar can help your writing to sound formal

In the healthcare industry, you'll be expected to write letters in a formal style. Our Writing sub-test reflects this by asking you to use this style for your letter.

Writing formally

When writing from professional to professional, or even from professional to patient (for some OET Test professions), you are expected to use formal language.

Towards the end of the case notes, you will find reminders of what genre and style you should use in the Writing task, such as:

- expand the relevant notes into complete sentences
- do not use note form.

Formal writing is polite, respectful, and non-judgmental.

You show these qualities in the language you use to make requests of the reader, how you present information to the reader and how you present information about the patient.

Let us look at some examples of informal and formal phrases and sentences:

Informal:

- Thanks for having a look at Priya
- I've sent her to you because she needs to lose some weight.

These phrases use the patient's first name and are not respectful toward her condition.

Formal:

- Thank you for seeing Mrs Priya Sharma.
- I am referring her to you for your specialist advice.

Both these phrases are respectful to the reader's role and are polite expressions about the patient, using her full name as part of the introduction.

To help you better understand genre and style, let's take a look at some ways you can identify the formality and tone of your letter as well as how to choose the right language during the Writing sub-test.

Using facts and not making judgements

When you present patient information, one way to be respectful and non-judgmental is to use facts:

- He writes with his left hand and drove a manual car before the fall.
- She works on her computer every day and carries a heavy laptop home.

When describing a patient's lifestyle choices, use **facts** instead of words that sound **judgmental**:

Judgment:	**Fact-based:**
Mr X is a heavy smoker	**Mr X smokes 30 cigarettes a day**
Mrs Y is a binge drinker OR Mrs Y is an alcoholic	**Mrs Y avoids drinking in the week but drinks 15 units of alcohol on an average weekend**
Ms Z does not exercise enough	**Ms Z admits she is only physically active once every three months.**

Using facts helps your reader know what the information means in terms of recommended norms. It allows you to avoid passing judgment on the patient and their lifestyle.

Starting and ending your letter

How you start and end the letter is important in ensuring you've used a formal tone from the beginning and in leaving the right impression at the end. It is common to end with a closing sentence that offers the reader the opportunity to contact you or to show appreciation for their involvement.

For example, you might close your letter by saying:

- If you require further information, please do not hesitate to contact me.
- Thank you for your continued management of this patient.

This handy guide explains the correct starting and ending language for your letter.

Contractions

Contractions are considered informal, so you should avoid using contracted forms of words while writing.

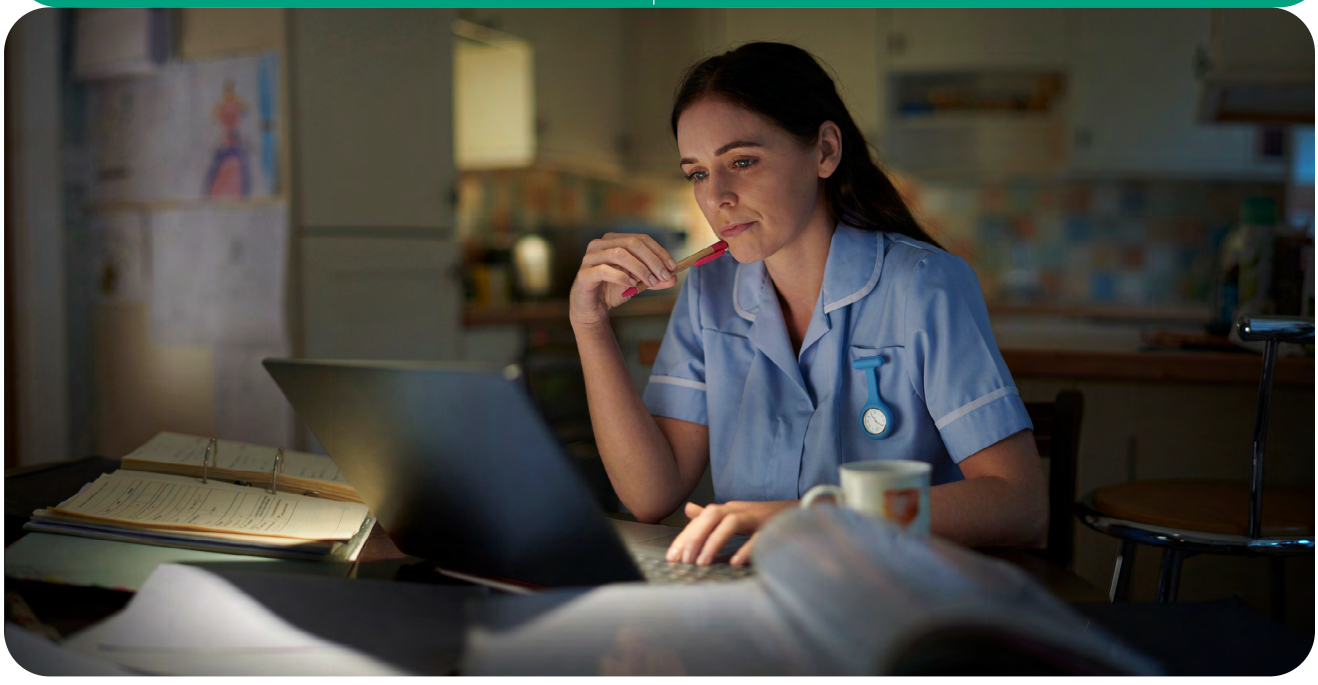
Let us look at some examples of informal versus formal grammar, related to contractions:

Informal:

- He's keen to return home.
- She's looking forward to holding her baby.
- She didn't follow the care plan correctly.

Formal:

- He is keen to return home.
- She is looking forward to holding her baby.
- She did not follow the care plan correctly.



Abbreviations

It is important to consider the reader when deciding when and where you abbreviate. Below are two examples to help you get a better idea of what we mean by this.

Example 1 | Reader: Endocrinologist

Mrs Sharma was diagnosed with NIDDM in 1999.

As you are writing to an endocrinologist, this abbreviation (NIDDM) would be very familiar and the condition is central to the patient's reason for seeing them, so it is appropriate to abbreviate.

For a medical specialist less familiar with the condition – an orthopaedic surgeon for example – the abbreviation is less appropriate. Any mention of the condition, because it may have some impact on the treatment the patient receives, should therefore be in full form.

Example 2 | Reader: Community Nurse

He was diagnosed with atrial fibrillation

There is more than one abbreviation used globally for Atrial Fibrillation: AF or AFib. As a result, it is best to use the full form of this condition rather than abbreviating it.

If you think your reader might not know what the abbreviation is, it is best to not abbreviate, otherwise, it will interrupt their reading.

Abbreviations that are more common to patients and healthcare professionals than their full form can be used in your letter.

Examples include: **MRI, BMI, CT, ECG.**

TIP

Keep the reader in mind!

The Genre and Style criterion is about being formal, using facts and refraining from judgement, as well as starting and ending your letter correctly. If you follow guidance above while keeping your reader in mind, you'll have the understanding you need to get a good score in the test.

05. Organising and laying out your letter

The fifth criterion used by assessors to score your Writing performance is Organisation and Layout. It covers how you order your letter and helps assessors decide whether your structure makes it easier or harder for the reader to understand.

In Chapter Five, we will explain:

- Why organisation and layout are important
- How to order information in your letter
- How to group information together into paragraphs

Putting your information in the right place

Once you have decided the information to include from the case notes, you now need to decide in what order you will present the information.

Each writing task and its case notes in the OET Test are different, so the situation you are describing and the requests you are making will be unique. This impacts how you structure your letter.

One way to think about your letter is that it's the patient's story. You often tell the patient's story when handing over a patient to colleagues at a shift change or over the phone when referring the patient to a specialist.

You might also adjust the order of the information in the story depending on who you're telling it to. This helps you to grab their attention and keep them engaged while you present the rest of the information. This is what you need to do with your letter.

Put yourself in the reader's shoes. If you received this letter, which information would you want first, second and so on?

Let's look at two different ways you can organise the letter depending on the patient's situation:

1. Chronologically

In some situations, the clearest way to organise the letter is around time. You start at the beginning and continue up to the present day, for example:

Reader: Endocrinologist

Paragraph one: Mrs Sharma initially presented on 29/12/18...

Paragraph two: A pathology report received on 05/01/2019...

Paragraph three: On 12/01/19...

Mrs Sharma's situation is quite routine to the reader. The writer uses dates at the start of each paragraph to separate the details of her visits. By doing this, the information follows a timeline that is clear to the reader and easy to follow.

2. Thematically

Another way to organise a letter is by putting the most important information first. We recommend organising the letter this way if there are several different aspects to the patient's current situation. For example, the patient's living and family situation, co-morbidities etc.

In these situations, presenting the information thematically will be most appropriate to the reader.

Let us look at an example:

Reader: Doctor

Paragraph One: Since October 2018, Mr Dunbar has shown signs of diabetic neuropathy... and has not been compliant with his medication regimen...

Paragraph Two: In June 2018, he had a myocardial infarction...His hypertension is controlled by Ramipril.

In this letter, similar to the previous example, there is a timeline of the patient's history, because it remains important for the reader to understand what happened and when.

However, the information is structured thematically rather than chronologically.

The first paragraph covers the patient's diabetes and non-compliance with both his medication and diet, as per the purpose of the letter (write a letter outlining the patient's history and requesting ongoing monitoring). The second paragraph focuses on related medical events and co-morbidities which are relevant background detail for the reader but of less importance.

In other letters, thematic paragraphs could focus on the patient's social history, previous advice and education they have received, relevant family history and the impact this has on how the patient feels about their condition, etc.

TIP

If the case notes describe an emergency, what happened to the patient six months ago becomes much less important to the reader. Instead, they are interested in what has just happened, what treatment has been provided and details of the patient's current situation.

Once they have this in mind, they can then scan through the rest of the letter to see if the history presents any additional insight. Keep this in mind whether you choose to write chronologically or thematically.

Review your paragraphs...

There is no limit to the paragraphs you can include. Use as many as are necessary to clearly communicate the information to the reader. Some situations may need less, and some may need more.

If you find you have written a very long paragraph in your letter, use the few minutes at the end to:

- make sure it is only covering one time period or one theme
- decide if you should break the paragraph into two.

...and the order of your sentences

It's not just about structuring the paragraphs in the clearest order for the reader. You also want to make sure that the important details don't get hidden within the paragraph. Apply the same approach to the order of your sentences. The sentence containing the most important information for that paragraph comes first, the next most important sentence comes in second and so on.

Choosing how to order your information is what is being assessed in this criterion. Even if you have included all the information the reader needs, but not in the order they need, then you will not have demonstrated this criterion correctly.

06. Understanding the right language

The final criterion of our Writing sub-test is Language, which includes grammar, vocabulary, punctuation, and spelling. Each of these language elements forms part of the assessment criteria.

Grammar

Grammar structures the English language and is an important element to get to know. While a lot of native speakers never formally study grammar, it can help you learn English more quickly.

Take a look at our three top read articles below:

- How to use connectors and improve your clarity in writing
- Do you know how to correctly write passive forms?
- Do you know how to use a relative clause?

Vocabulary

Vocabulary is an important part of the OET Test because it demonstrates your ability to communicate in the professional language that the audiences of your Writing and Speaking sub-test will be familiar with.

Take a look at this example:

- The importance of writing in a factual way about a patient's lifestyle

Punctuation

Punctuation adds clarity to your writing. It can help you better communicate your message to your reader. Read through these top-read articles below.

- Use semicolons to write clear lists
- Are you worried about punctuation?

Spelling

Spelling is important in the Writing sub-test, and some misspelled words will stand out more than others. However, you won't need to be perfect to achieve a B.

FINAL TIPS

Assessment

Writing is assessed against specific criteria. These are available for you to read, and it is important that you do. The descriptors tell you what it is the assessor is looking for and how to demonstrate this in your responses. To get the grade you want, you must score highly across ALL the criteria, so make sure you do not just focus on the obvious ones like Language. Accurate grammar is important but not more important than any of the other criteria.

Completing your answers

You can complete the paper-based Writing test in either pen or pencil depending on your personal preference. Your handwriting is not assessed but it does need to be clear enough for the assessor to be able to read. You might find it quicker and clearer to cross out any mistakes you make while writing and carry on with the correction rather than erasing and writing over the top. Only the answer written on the lined paper in the answer booklet will be assessed, so make sure you only use the blank page for planning. For the OET Test on Computer at a venue or OET Test@Home®, you will type your letter into the answer box provided on your screen.

Top tip for Writing

It is important that by the time you get to the Writing sub-test, you still have some energy left. Make sure you build up your stamina by practising Listening for 40 minutes then Reading for 60 minutes then Writing for 40 minutes at least once a week.

Get Writing test ready with these great resources

- OET Writing Course
- Helpful tips and advice to support you every step of the way.
- Learn from some Graded Writing Samples

Notes

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