

United States Medical Licensing Examination® (USMLE®)

REQUEST FOR TEST ACCOMMODATIONS

Use this form if you are requesting accommodations on USMLE for the first time

The National Board of Medical Examiners® (NBME®) processes requests for test accommodations on behalf of the USMLE program

If you have a documented disability covered under the Americans with Disabilities Act (ADA), you must notify the USMLE in writing each time you apply for a Step examination for which you require test accommodations. Submitting this form constitutes your official notification.

- Review the USMLE Guidelines for Test Accommodations at www.usmle.org for a detailed description of how to document a need for accommodations.
- Complete all sections of this request form; submit the form and all required documentation to Disability Services once you have submitted your Step exam application to your registration entity.
- NBME will acknowledge receipt of your request by e-mail and audit your submission for completeness. If you do not receive an e-mail acknowledgement within two business days of submitting your request, please contact Disability Services at 215-590-9700 or disabilityservices@nbme.org. You may be asked to submit additional documentation to complete your request.
- Requests are processed in the order in which they are received. Processing cannot begin until sufficient information is received by NBME **and** your Step exam registration is complete. Please allow at least 60 days for processing of your request.
- The outcome of our review will not be released via telephone. All official communications regarding your request will be made in writing. If you wish to modify or withdraw a request for test accommodations, contact Disability Services by e-mail at disabilityservices@nbme.org or by telephone at 215-590-9700.

As explained in the Guidelines to Request Test Accommodations (www.usmle.org), you **MUST provide supporting documentation verifying your current functional impairment.**

Submit the following with this form:

- ✓ A **personal statement** describing your disability and its impact on your daily life and educational functioning.
- ✓ A **complete and comprehensive evaluation** from a qualified professional documenting your disability.
- ✓ **Supporting documentation** such as academic records; score transcripts for previous standardized exams; verification of prior academic/test accommodations; relevant medical records; previous psycho-educational evaluations; faculty or supervisor feedback; job performance evaluations; clerkship/clinical course evaluations; etc.

Please be sure to review the Guidelines for more detailed information regarding supporting documentation.

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Section A: Exam Information

Place a check next to the examination(s) for which you are **currently registered and** requesting test accommodations: (Check all that apply)

- Step 1
- Step 2 CK (Clinical Knowledge)
- Step 2 CS (Clinical Skills)
- Step 3*

*Please be aware that additional test time for Step 3 may involve 3 to 5 days of testing, depending on the requested accommodation (See Section C1).

Section B: Biographical Information

Please type or print.

B1. Name: _____
Last First Middle Initial

B2. Gender: Male Female

B3. Date of Birth: _____

B4. USMLE # __ - ____ - ____ - __ (required)

B5. Address:

Street

City State/Province Zip/Postal Code

Country

Preferred Telephone Number

E-mail address

B6. Medical School Name: _____

Country of Medical School: _____ Date of Medical School Graduation: _____

Section C: Accommodations Information

C1. Step 1, Step 2 CK, or Step 3 (computer-based examinations)

Check the appropriate box to indicate the accommodations you are requesting. Check **ONLY ONE** box for the exam(s) for which you are currently registered:

STEP 1:

Additional Break Time

- Additional break time over 1 day
- Additional break time over 2 days

Additional Testing Time

- 25% Additional test time (Time and 1/4) over 2 days
- 50% Additional test time (Time and 1/2) over 2 days
- 100% Additional test time (Double time) over 2 days
- Additional break time and 50% Additional test time (Time and 1/2) over 2 days

STEP 2 CK:

Additional Break Time

- Additional break time over 2 days

Additional Testing Time

- 25% Additional test time (Time and 1/4) over 2 days
- 50% Additional test time (Time and 1/2) over 2 days
- 100% Additional test time (Double time) over 2 days
- Additional break time and 50% Additional test time (Time and 1/2) over 2 days

STEP 3:

Additional Break Time

- Additional break time over 4 days

Additional Testing Time

- 25% Additional test time (Time and 1/4) over 3 days
- 50% Additional test time (Time and 1/2) over 4 days
- 100% Additional test time (Double time) over 5 days
- Additional break time and 50% Additional test time (Time and 1/2) over 4 days

Describe any other accommodation(s) you are requesting for **Step 1, Step 2 CK, or Step 3.**

C2. STEP 2 CS (Clinical Skills)

Review the Step 2 CS Onsite Orientation video and Step 2 CS Content Description and General Information Booklet at www.usmle.org for detailed information about the format and delivery of the Step 2 CS examination.

Describe the accommodations you are requesting for each section of Step 2 CS (i.e., patient encounter, patient note). If you are requesting additional time, state the **amount** of additional time you require in **minutes per encounter or note.**

- Patient Encounter: _____
- Patient Note: _____

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C3. Do you require wheelchair access at the examination facility? Yes No
If yes, please indicate the number of inches required from the bottom of the table to the floor: _____

Section D: Information About Your Impairment

D1. List the **specific DSM/ICD diagnostic code(s) and disability** for which you are requesting accommodations and report the year that it was **first** diagnosed.



<u>DIAGNOSTIC CODE</u>	<u>DISABILITY</u>	<u>YEAR DIAGNOSED</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

D2. Personal Statement

 **Attach a signed and dated personal statement describing your impairment(s) and how a major life activity is substantially limited.** The personal statement is your opportunity to tell us how your physical or mental impairment(s) substantially limits your current functioning in a major life activity and how the standard examination conditions are insufficient for your needs. In your own words, describe the impact of your disability on your daily life (do not confine your statement to standardized test performance) and provide a rationale for why the specific accommodation(s) you are requesting are necessary in the context of this examination.

Section E: Accommodation History

E1. Standardized Examinations

-  **Attach copies of your score report(s) for any previous standardized examination taken.**
-  **If accommodations were provided, attach official documentation from each testing agency confirming the test accommodations they provided.**



List the accommodations received for previous standardized examinations such as college, graduate, or professional school admissions tests and professional licensure or certification examinations (if no accommodations were provided, write NONE).

	<u>DATE(S) ADMINISTERED</u>	<u>ACCOMMODATION(S) PROVIDED</u>
<input type="checkbox"/> SAT®, ACT®	_____	_____
<input type="checkbox"/> MCAT®	_____	_____
<input type="checkbox"/> GRE®	_____	_____
<input type="checkbox"/> GMAT®	_____	_____
<input type="checkbox"/> LSAT®	_____	_____
<input type="checkbox"/> DAT®	_____	_____
<input type="checkbox"/> COMLEX®	_____	_____
<input type="checkbox"/> Other (specify)	_____	_____

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E2. Postsecondary Education

List each school and all formal accommodations you receive/received, and the dates accommodations were provided:

-  **Attach copies of official records from each school(s) confirming the accommodations they provided.**
-  **If you receive/received accommodations in medical school and/or residency, have the appropriate official at your medical school/residency complete and submit the USMLE Certification of Prior Test Accommodations form available at www.usmle.org.**

	<u>SCHOOL</u>	<u>ACCOMMODATIONS PROVIDED</u>	<u>DATES PROVIDED</u>
Medical/Graduate/ Professional School	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Undergraduate School	_____	_____	_____
	_____	_____	_____

E4. Primary and Secondary School

List each school and all formal accommodations you received, and the dates accommodations were provided:

-  **Attach copies of official records from each school listed confirming the accommodations they provided.**

	<u>SCHOOL</u>	<u>ACCOMMODATIONS PROVIDED</u>	<u>DATES PROVIDED</u>
High School	_____	_____	_____
	_____	_____	_____
Middle School	_____	_____	_____
	_____	_____	_____
Elementary School	_____	_____	_____
	_____	_____	_____

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Section F: Certification and Authorization

To the best of my knowledge and belief, the information recorded on this request form is true and accurate. I understand that my request for accommodations, including this form and all supporting documentation, must be received by the NBME sufficiently in advance of my anticipated test date in order to provide adequate time to evaluate and process my request.

I acknowledge and agree that any information submitted by me or on my behalf may be used by the USMLE program for the following purposes:

- Evaluating my eligibility for accommodations. When appropriate, my information may be disclosed to qualified independent reviewers for this purpose.
- Conducting research. Any disclosure of my information by the USMLE program will not contain information that could be used to identify me individually; information that is presented in research publications will be reported only in the aggregate.

I authorize the National Board of Medical Examiners (NBME) to contact the entities identified in this request form, and the professionals identified in the documentation I am submitting in connection with it, to obtain further information. I authorize such entities and professionals to provide NBME with all requested further information.

I further understand that the USMLE reserves the right to take action, as described in the Bulletin of Information, if it determines that false information or false statements have been presented on this request form or in connection with my request for test accommodations.

Name (print): _____

Signature: _____ Date: _____

E-mail (as a pdf), fax or mail your completed request form and supporting documents to the address below at the same time you submit your Step examination application.

**Disability Services
National Board of Medical Examiners
3750 Market Street
Philadelphia, PA 19104-3190
Telephone: (215) 590-9700
Facsimile: (215) 590-9422
E-mail: disabilityservices@nbme.org**