

United States Medical Licensing Examination® (USMLE®)

Certification of Prior Test Accommodations

Please type or print. To be completed and signed by medical school official responsible for student disability services.

Applicant Name: \_\_\_\_\_ USMLE ID#: \_\_ - \_\_ - \_\_ - \_\_ - \_\_ - \_\_

I certify that \_\_\_\_\_ has officially approved and continuously  
Name of School  
provided the following accommodations for the above applicant beginning on \_\_\_\_\_  
Date (Month/Year)

1. Accommodation(s) provided for **classroom and clinical coursework**: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for accommodation(s): \_\_\_\_\_

2. Accommodation(s) provided for **written exams**: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for accommodation(s): \_\_\_\_\_

3. Accommodation(s) provided for **clinical skills exams**: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for accommodation(s): \_\_\_\_\_

Name of School Official: \_\_\_\_\_ Title: \_\_\_\_\_  
Print Name of Official Title of Official

Signature of Official: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

**Mail, fax, or e-mail completed form to:**

Disability Services  
National Board of Medical Examiners  
3750 Market Street  
Philadelphia, PA 19104-3190  
Telephone: (215) 590-9700  
FAX: (215) 590-9422  
E-mail: [disabilityservices@nbme.org](mailto:disabilityservices@nbme.org)  
Call or e-mail to verify receipt of Fax and mail submissions