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
Call or e-mail to verify receipt of Fax and mail submissions