Certification of Prior Test Accommodations (CPTA)

USMLE[SM]

TO BE COMPLETED AND SIGNED BY MEDICAL SCHOOL OFFICIAL RESPONSIBLE FOR ACADEMIC ACCOMMODATIONS

Applicant Name: ________________ **USMLE ID #:** ________________

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

1. Accommodation(s) provided for **computer-based, written, or other assessments:**

____

____

Reason for accommodation(s):

____

If the applicant is requesting accommodations for **Step 3**:

2. Accommodation(s) provided for **clinical education settings (e.g., ambulatory, inpatient, laboratory- based clinical work):**

____

____

Reason for accommodation(s):

____

Name of School Official: ________________________________

Title: ________________________________

Signature of Official: ________________________________

Date: ________________________________

Telephone Number: ________________________________

Email or fax your completed form to:

Disability Services NBME
3750 Market Street
Philadelphia, PA 19104-3190
Telephone: (215) 590-9700
Fax: (215) 590-9422
E-mail: disabilityservices@NBME.org

Please Note: **This form is not a Request for Test Accommodations**. Go to https://www.usmle.org/step-exams/test-accommodations for detailed information and instructions on submitting a request for accommodations.