United States Medical Licensing Examination™ (USMLE™)

Step 2 Clinical Skills
Applicant’s Request for Test Accommodations

In order to submit a request for test accommodations for USMLE Step 2 CS:

- Complete and submit the USMLE Step 2 CS Registration form Parts A and B
- Review the current Content Description and General Information available at www.usmle.org. This information will orient you to the exam format.
- Complete the Step 2 CS Applicant’s Request for Test Accommodations.

In order to have your request processed without delay you MUST:

1. Provide supporting documentation verifying your functional impairment. Supporting documentation should be submitted unbound. Please see documentation submission information on page 5. In order to document your need for accommodation as completely as possible, please attach:
   - Evaluation reports of appropriate professionals printed on letterhead and signed by the evaluator(s). Psychoeducational testing should be reported using age norms for all measures where available.
   - Primary documentation (report cards, teacher notes, behavioral observations, medical records, etc.)
   - A personal statement describing your disability and its impact on your daily life and educational functioning. Do not confine your comments to standardized test performance. Please discuss your overall functioning in both academic and non-academic settings.

2. Provide specific request(s) for test accommodations:
   - Test accommodations may be provided on one or more section of Step 2 CS. Sections of the exam include:
   - You must document a functional impairment that substantially impacts the tasks required for a specific section of the examination in order to be considered for accommodations on that section of the examination.

Please note these important facts:

- NBME will acknowledge receipt of your request and audit your documentation for completeness. If your request does not include sufficient documentation of a current substantial functional impairment to warrant review, you will receive written notice of the documentary deficiencies and will be required to provide additional documentation.
- Submitting insufficient documentation with your request for test accommodations may substantially lengthen the decision making process regarding your request.
- Information regarding the granting or denial of test accommodations will NOT be released via telephone. All official communications regarding your request will be made in writing. Should you wish to modify or withdraw a request for test accommodations, please contact Disability Services at 215-590-9509.

All official communications regarding requests for test accommodations, including final decisions, will be communicated in writing only.
Section A: Biographical Information

1. Name: ____________________________________________
   Last                         First                         Middle Initial

2. Gender: Male     Female

3. Date of Birth: _______________________

4. SS# __ __ __ - __ __ - __ __ __ __    5. USMLE # __ - __ __ __ - __ __ __ - __
   (if known)

5. A. Permanent Address: ________________________________________________________________
   Street
   __________________________________________________________________________________
   City                                      State/Province            Zip/Postal Code
   __________________________________________________________________________________
   Country
   Daytime Telephone Number
   __________________________________________________________
   Alternate Telephone Number
   __________________________________________________________
   E-mail address
   __________________________________________________________

B. Temporary/ Mailing Address: ____________________________
   Use this address from: __/__/____ to __/__/____
   Street
   __________________________________________________________
   City                                      State/Province            Zip/Postal Code
   __________________________________________________________
   Country
   Daytime Telephone Number
   __________________________________________________________
   Alternate Telephone Number
   __________________________________________________________
   E-mail address
   __________________________________________________________

6. Medical School: ___________________________________________________________
Section B: Nature of Disability

7. Indicate the **nature of the disability** and the **year** it was first professionally diagnosed (select all that apply):

   Sensory Impairments:
   - Hearing Disability ________  Visual Disability ________

   Learning Impairments:
   - Reading Disability ________
   - Writing Disability ________  Other: ________

   Language Impairments:
   - Receptive Language Disorder ________  Expressive Language Disorder ________
   - Mixed Receptive/Expressive Language Disorder ________  Other: ________

   Medical Impairments:
   - Mobility/Motor ________  Diabetes/Thyroid Dysfunction ________
   - Epilepsy/Neurological ________  Other: ________

   Mental Health /Executive Function Impairments:
   - Anxiety Disorder ________
   - Attention Deficit Hyperactivity Disorder ________  Other: ________

Section C: Accommodations Information

- Accommodation(s) must be appropriate to the disability
- For each accommodation requested indicate the section(s) of the examination you believe is affected (i.e., orientation, patient encounter, patient note)
- If you are requesting additional testing or break time, please indicate the amount of additional time requested in minutes (DO NOT indicate time in multiples of standard time, such as time and one half, double time, etc.)

8. What accommodation(s) are you requesting?

A. Section of Exam:

   Accommodation Requested:
B. Section of Exam:  
___________________________________________________________________________________________
Accommodation Requested:  
___________________________________________________________________________________________

C. Section of Exam:  
____________________________________________________________________________________________
Accommodation Requested:  
____________________________________________________________________________________________

9. Do you require wheelchair access at the examination facility?  
☐ yes  ☐ no

If you require an adjustable height table, please indicate the number of inches from the floor: ______________

Section D: Accommodation History

10. Prior classroom or test accommodations that you have received:

A. Standardized Examinations  ☐ yes  ☐ no

Medical College Admission Test (MCAT):
Month/Year ________________________________
Accommodation received ______________________________________________________________
(If extra time, note amount given ____________)

Other:
Month/Year ________________________________
Accommodation received ______________________________________________________________
(If extra time, note amount given ____________)

B. Medical School  ☐ yes  ☐ no

Accommodation received
Clinic: ______________________________________________________________
Classroom: ______________________________________________________________
Date Approved ______________________________

If yes, have an appropriate official at your medical school complete the Certification of Prior Test Accommodations form.

C. College  ☐ yes  ☐ no

If yes, accommodations received ________________________________________________________________
D. Secondary or elementary school  
☐ yes  ☐ no
If yes, accommodations received

11. **Authorization (You must sign and date this item in order to have your request processed)**

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

Signature: ___________________________      Date: ________________

**DO NOT SUBMIT:**
- Original documents; keep the original and submit a copy
- Research articles, resumes, curriculum vitae
- Handwritten letters from physicians or evaluators
- Handwritten letters from physicians or evaluators
- Documentation previously submitted to Disability Services
- Documentation previously submitted to your registration entity
- Previous correspondence from Disability Services
- Multiple copies of documentation (i.e., faxed and mailed copies of a document)
- Staples, clips, binders, page protectors, folders, or similar items

Please note that submitting duplicate documentation and/or bound documentation may delay a decision regarding your request as all documentation must be processed.

**DO SUBMIT:**
- Legible copies
- All documents in English. You are responsible for providing certified English translations of foreign-language documentation
- Typed or printed letters and reports from evaluators
- Documentation from childhood if you are requesting accommodations based on a developmental disorder, i.e. LD, ADHD, Dyslexia
- Documentation of your functional impairment in activities beyond test-taking
- Documentation of your functional impairment beyond self-report

Mail your completed questionnaire and documents to:

**Students / Graduates of US & Canadian Medical Schools**
Testing Coordinator, Disability Services, National Board of Medical Examiners,  
3750 Market Street, Philadelphia, PA 19104-3190.  
215-590-9509

**Students / Graduates of International Medical Schools**
Test Accommodations Coordinator, Educational Commission for Foreign Medical Graduates  
3624 Market Street, Philadelphia, PA 19104 USA.

Please keep a copy of your completed request form for your records.