Subsequent Request for Test Accommodations / Arrangements

USE THIS FORM IF YOU WERE PREVIOUSLY PROVIDED TEST ACCOMMODATIONS / ARRANGEMENTS FOR THE USMLE

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

In order for us to process your subsequent request:

- Complete all sections of this request form; submit the form and any required documentation to Disability Services. Do not resubmit supporting documentation already provided with a previous request.
- You must have a completed registration for the USMLE and your scheduling permit must be placed on hold.
- Subsequent requests for the same accommodations/arrangements previously provided will be processed in an expedited manner. Please allow at least 60 business days for processing of new or different accommodations/arrangements.
- Disability Services 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 subsequent request, please contact Disability Services at 215-590-9700, or disabilityservices@nbme.org.
- 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, contact Disability Services by e-mail at disabilityservices@nbme.org.

Section A: Exam Information (Please type or print.)

A1. Place a check next to the examination(s) for which you are currently registered and requesting test accommodations/arrangements: (Check all that apply):

☐ Step 1
☐ Step 2 Clinical Knowledge (CK)
☐ Step 3

B: Biographical Information. (Please type or print.)

B1. Name:

Last First Middle Initial

B2. USMLE #: _____ (required)

B3. Email address: _____

Section C: Request Accommodations / Arrangements for a Subsequent Exam

C1. Do you require wheelchair access at the examination facility? ☐ Yes ☐ No

If yes, and you require an adjustable height computer table, indicate the number of inches required from the bottom of the table to the floor:_____

C2. If you previously received accommodations or arrangements for the USMLE (i.e., Step 1, Step 2 CK or Step 3, check the appropriate box below:

☐ I am requesting **the same accommodations / arrangements** previously provided for the USMLE. *Please skip to section C4.

☐ I am requesting **new or different accommodations / arrangements** from those previously provided due to a change in the nature or extent of my condition. Please complete the rest of section C. Please note you should submit additional supporting documentation.

Describe the new or different accommodations/arrangements you are requesting and the reason for the change:

Attach documentation of the change in your disability supporting your request.

C3. List the **specific DSM/ICD diagnostic code(s) and disability** for which you are requesting accommodations / arrangements and report the year that it was **first** diagnosed.

DIAGNOSTIC CODE	DISABILITY	YEAR DIAGNOSED

C4. Check the appropriate box below to indicate the accommodations / arrangements you are requesting for the exam(s) for which you are currently registered:

STEP 1: Check ONLY ONE box

Additional Break Time

- ☐ Additional break time with standard test blocks **over 1 day**
- ☐ Additional break time with shortened test blocks **over 1 day**
- ☐ Additional break time with shortened test blocks **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 and Testing Time

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

STEP 2 CK: Check ONLY ONE box

Additional Break Time

- ☐ Additional break time with standard test blocks **over 2 days**
- ☐ Additional break time with shortened test blocks **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 and Testing Time

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

STEP 3: Check ONLY ONE box

Additional Break Time

- ☐ Additional break time with standard test blocks **over 3 days**
- ☐ Additional break time with shortened blocks **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 and Testing Time

- ☐ Additional break time and 25% Additional test time (Time and 1/4) **over 4 days**
- ☐ Additional break time and 50% Additional test time (Time and 1/2) **over 4 days**
- ☐ Additional break time and 100% Additional test time (Double time) **over 7 days**

Section D: 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 subsequent request for accommodations/arrangements, including this form and all supporting documentation, must be received by Disability Services 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 USMLE *Bulletin of Information*, if it believes 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

Submitting Your Completed Request Form:
(Do Not Send duplicate documents and Do Not Send by multiple methods as this will delay processing)

- **Please submit your request form and supporting documentation via e-mail or fax.**
- **E-mail:** Send to disabilityservices@nbme.org. Maximum file size is 15 MB (including text in body of email, headers and all attachments). Files larger than 15 MB may require separate emails. All attachments must be in PDF format. Please scan your documents into as few PDFs as possible. Photographs of Personal Items may be in digital format such as JPEGs/JPGs. We are not able to access embedded links.
- **Fax:** Submit your completed request form to (215) 590-9422.

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