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 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 OfficialTitle 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