Reconsideration Request for Test Accommodations

USE THIS FORM IF YOU RECEIVED A DECISION LETTER AND ARE REQUESTING THAT WE RECONSIDER OUR DECISION FOR THE SAME STEP EXAM REGISTRATION(S).

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

In order for us to reconsider your request you must:

- Complete all sections of this request form; submit the form and new and compelling supporting documentation or information that Disability Services has not already reviewed.
- Have a current eligibility period. If your eligibility has expired, or if you test before our review is complete, Disability Services will discontinue the reconsideration review process. It is your responsibility to monitor your registration status and eligibility period throughout the entire reconsideration process.

IMPORTANT

- You may request ONE (1) reconsideration review per registration so be sure to include all supportive documentation at this time.
- Do NOT resend documentation that you previously submitted.
- As a reminder, requests for accommodations should generally be accompanied by appropriate, comprehensive documentation from a qualified professional dated within a reasonable time-frame sufficient to document your current specific impairment(s). If this information was not provided with your initial request, or was not comprehensive, we recommend that you provide it or supplement it in your request for reconsideration, if possible. We do not ask that you undergo any new or redundant evaluation, assessment, or testing when you seek reconsideration. We will consider only new objective evidence to support your request.
- Disability Services will acknowledge receipt of your request for reconsideration 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 request for reconsideration, please contact us at 215-590-9700 or disabilityservices@nbme.org.
- The outcome of our reconsideration will not be released via telephone. All official communications regarding your reconsideration request will be made in writing. If you wish to modify or withdraw a request for reconsideration, contact Disability Services by e-mail at disabilityservices@nbme.org.

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

A1. Name:

Last	First	Middle Initial

A2. USMLE #: _____ (required)

Section B: Reconsideration Request for Test Accommodations (Please type or print.)

B1. List the **specific DSM/ICD diagnostic code(s) and disability** for which you are requesting accommodations and report the year that it was **first** diagnosed.

DIAGNOSTIC CODE	DISABILITY	YEAR DIAGNOSED

B2. Check the appropriate box below to indicate the accommodations you are requesting for the exam(s) for which you are currently registered and requesting reconsideration:

STEP 1: Check ONLY ONE box

Additional Break Time

- ☐ Additional break time **over 1 day**
- ☐ Additional break time **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 **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 **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**

B3. Describe any other accommodation(s) you are requesting for **Step 1, Step 2 CK, or Step 3**.

Section C: 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 request for reconsideration, including this form and all supporting documentation, must be received by the NBME 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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