

---

# UNITED STATES MEDICAL LICENSING EXAMINATION™(USMLE)™

---

## 2010 STEP 3 APPLICATION INSTRUCTIONS

The Federation of State Medical Boards of the United States, Inc. (FSMB)  
Telephone: 817-868-4041 Fax: 817-868-4098  
E-mail Address: [usmle@fsmb.org](mailto:usmle@fsmb.org)  
Website Address: [www.fsmb.org](http://www.fsmb.org)

Use the 2010 application if you will take Step 3 between November 1, 2009 and December 31, 2010.

### APPLICATION MATERIALS

The application materials consist of the 2010 USMLE Step 3 Application Form with instructions, and the state-specific instructions posted on the FSMB website – [www.fsmb.org](http://www.fsmb.org). Sample test questions and case simulations are available at [www.usmle.org](http://www.usmle.org).

Application must be made on the current 2010 application form and a new application submitted each time you apply for Step 3. USMLE policy information regarding eligibility requirements, examination content, testing conditions, scoring and score reporting appear in the *USMLE Bulletin of Information* at [www.usmle.org](http://www.usmle.org). By signing the Step 3 application, you certify having read the application instructions, the *USMLE Bulletin of Information* and related materials from the FSMB website.

### COMPLETING AND MAILING YOUR APPLICATION

Applications are processed by date of receipt. Allow approximately 1-3 weeks for processing once the FSMB receives your application. You must provide an e-mail address on your application. Not providing an e-mail address will significantly delay notification of your Scheduling Permit and Score Report.

Mail your Step 3 application, required document(s) and fee to the address listed under the state-specific instructions on the FSMB website. Your application, fee and all required documents must be received at the FSMB by Sept. 3, 2010. Any registration incomplete after this date will be cancelled. You can monitor the status of your application using the USMLE Candidate Website located on the FSMB website.

### STEP 3 ELIGIBILITY REQUIREMENTS

Consult the *USMLE Bulletin of Information* and the state-specific eligibility requirements posted on the FSMB's website to ensure you are eligible to sit Step 3 for the state you signify on the application. If it is determined that you do not meet eligibility requirements at the time your application is received, your registration will be cancelled and a portion of the application fee withheld.

### FEE

For specific fee information, consult the FSMB website. Make check or money order payable to the FSMB in U.S. currency. Record your name, USMLE Identification Number and U.S. Social Security Number or National Identification Number on your check or money order. The USMLE Step 3 fee is nonrefundable and nontransferable from one eligibility period to another or from one application to another.

### NAME CHANGE/CORRECTION OR ADDRESS CHANGES

Name change or corrections require a written signature. For complete instructions, refer to the Name Change/Correction Authorization form posted to the FSMB website – [www.fsmb.org](http://www.fsmb.org) Address or e-mail address changes made after your application is received in our office must be done through the Candidate website available through the FSMB website.

### RECEIPT OF YOUR SCHEDULING PERMIT

Once your application is registered and eligibility status approved, an electronic Scheduling Permit notification will be sent to you at the e-mail address provided on your application. The electronic Scheduling Permit includes your assigned eligibility period, which begins immediately (90 days plus two additional weeks for processing), as well as other pertinent information and instructions. Consult the *USMLE Bulletin of Information* for more details.

You will not be allowed to sit for the exam without presenting your Scheduling Permit to the proctor on each day of the exam. It is your responsibility to contact the FSMB if you have not received your notification of your Scheduling Permit in a timely manner after submitting your Step 3 application. **NOTE:** The name on your unexpired, government-issued photo identification that you are required to present at the test center must match exactly the name on your Scheduling Permit.

The USMLE program is now producing Scheduling Permits and Score Reports as an electronic document. Therefore, an e-mail address is a **mandatory** field that must be completed on the Step 3 application form in order to instruct you on obtaining and printing your Scheduling Permit and Score Report.

## SCHEDULING YOUR EXAMINATION

Prometric schedules test dates on a first-come, first-served basis. **You are urged to schedule your appointment and test early in your eligibility period.** This will provide the greatest flexibility in the event you must reschedule your appointment. Consult the *USMLE Bulletin of Information* for more detailed information on scheduling with Prometric.

## ELIGIBILITY EXTENSIONS

Under most circumstances, a one-time 90-day extension of your eligibility period is possible. Requests must be received no later than 10 days after the end of the current eligibility period. For further details, including the fee for this service, consult the FSMB website: [www.fsmb.org](http://www.fsmb.org)

## REQUEST FOR TEST ACCOMMODATIONS

If you have a documented disability covered under the Americans with Disabilities Act (ADA) and require test accommodations, you must submit the official request form each time you apply for Step 3 **and** check Item 13 on your Step 3 application to indicate that you are submitting a request for accommodations with supporting documentation.

For complete instructions and information on how to apply for test accommodations, please review the USMLE *Request for Test Accommodations for Examinees with Disabilities*, available on the FSMB website at [www.fsmb.org](http://www.fsmb.org). Your test accommodation request must be received in our office prior to your Step 3 Application being approved or your request will not be processed. If you have questions or inquiries regarding test accommodations you may contact Examination Services at (817) 868-4041 or e-mail [exam@fsmb.org](mailto:exam@fsmb.org).

## MAILING THE APPLICATION FORM AND FEES

Mail the three-page application and the fee to **one** of the following addresses:

*Via **First Class** U.S. Postal Service ONLY  
Without tracking or signature required services:*

Attn: Wholesale Lockbox  
Exam Department  
Federation of State Medical Boards  
P.O. Box 970172  
Dallas, TX 75397-0172

*Via **express tracking services** for  
FedEx, DHL, UPS or U.S. Postal  
Service **ONLY:***

Federation of State Medical Boards  
Attn: Exam Department  
Suite 300  
400 Fuller Wiser Road  
Euless, TX 76039  
*No Saturday or Sunday deliveries accepted*

## BOARD CODE LIST (ALPHABETICAL)

Use only for Item 1.

001 Alabama	014 Illinois	028 Nebraska	041 South Carolina
002 Alaska	015 Indiana	029 Nevada	042 South Dakota
003 Arizona	016 Iowa	030 New Hampshire	043 Tennessee
004 Arkansas	017 Kansas	031 New Jersey	044 Texas
005 California	018 Kentucky	032 New Mexico	045 Utah
006 Colorado	019 Louisiana	033 New York	046 Vermont
007 Connecticut	020 Maine	034 North Carolina	054 Virgin Islands, United States
008 Delaware	021 Maryland	035 North Dakota	047 Virginia
009 District of Columbia	022 Massachusetts	036 Ohio	048 Washington
010 Florida	023 Michigan	037 Oklahoma	948 Washington Osteo
011 Georgia	024 Minnesota	038 Oregon	050 Wisconsin
055 Guam	025 Mississippi	039 Pennsylvania	049 West Virginia
012 Hawaii	026 Missouri	053 Puerto Rico	051 Wyoming
013 Idaho	027 Montana	040 Rhode Island	

## COUNTRY CODE LIST (ALPHABETICAL)

118 Afghanistan	228 Chad	422 Grenada	630 Martinique
120 Albania	101 Channel Islands	427 Guadeloupe	632 Mauritania
125 Algeria	231 Chile	055 Guam	634 Mauritius
056 American Samoa	243 China	429 Guatemala	141 Mayotte
127 Andorra	108 Christmas Island	435 Guinea	669 Media
128 Angola	109 Cocos Islands	436 Guinea-Bissau	649 Mexico
103 Anguilla	264 Colombia	438 Guyana	082 Micronesia
129 Antarctica	265 Comoros	440 Haiti	084 Midway Islands
130 Antigua & Barbuda	727 Congo	451 Honduras	650 Moldova
131 Antilles, Netherlands, Aruba, Bonaire, Curacao, St Eusta, St Maart	117 Cook Islands	462 Hong Kong	651 Monaco
132 Argentina	100 Corsica	473 Hungary	652 Mongolia
138 Armenia	270 Costa Rica	484 Iceland	653 Montenegro
107 Aruba	273 Croatia	495 India	654 Montserrat
143 Australia	275 Cuba	506 Indonesia	655 Morocco
154 Austria	667 Curacao	517 Iran	657 Mozambique
156 Azerbaijan	968 Cyprus	528 Iraq	209 Myanmar
111 Azores	280 Cyprus (Greek)	539 Ireland	658 Namibia
157 Bahamas	281 Cyprus (Turkish)	102 Isle of Man	659 Nauru
155 Bahrain	966 Czech Republic	550 Israel	672 Nepal
113 Balearic Islands	286 Czechoslovakia	561 Italy	660 Netherlands
160 Bangladesh	297 Denmark	563 Ivory Coast	665 Netherlands Antilles
162 Barbados	300 Djibouti	566 Jamaica	144 New Caledonia
164 Belarus	305 Dominica	572 Japan	671 New Zealand
090 Belau	308 Dominican Republic	575 Jordan	890 Newer Calcedonia
165 Belgium	980 Dutch East Indies	576 Kazakhstan	682 Nicaragua
166 Belize	410 East Germany	577 Kenya	688 Niger
169 Benin	319 Ecuador	580 Kiribati	690 Nigeria
170 Benin	915 Egypt	969 Korea	147 Niue
171 Bermuda	341 El Salvador	584 Kuwait	110 Norfolk Island
173 Bhutan	946 England	587 Kyrgyz Republic	582 North Korea
176 Bolivia	355 Equatorial Guinea	590 Laos	152 North Vietnam
668 Bonaire	345 Eritrea	595 Latvia	952 North Yemen
178 Bosnia-Herzegovina	360 Estonia	605 Lebanon	949 Northern Ireland
180 Botswana	366 Ethiopia	607 Lesotho	693 Norway
187 Brazil	367 Falkland Islands	610 Liberia	
115 British Antarctic Territory	140 Faroe Islands	613 Libya	695 Oman
970 British East Africa	368 Fiji	615 Liechtenstein	088 Pacific Islands Trust Territory
116 British Indian Ocean Territory	374 Finland	616 Lithuania	704 Pakistan
945 British Virgin Islands	396 France	618 Luxembourg	715 Panama
191 Brunei	398 French Guiana	619 Macao	720 Papua New Guinea
198 Bulgaria	399 French Polynesia	621 Macedonia	726 Paraguay
207 Burkina Faso	145 French Southern/Antarctic Territories	620 Madagascar	737 Peru
211 Burundi	397 Gabon	112 Madeira Islands	748 Philippines
215 Cambodia	402 Gambia	622 Malawi	105 Pitcairn Islands
217 Cameroon	406 Georgia	624 Malaysia	759 Poland
098 Canada	409 Germany	623 Maldives	770 Portugal
114 Canary Islands	412 Ghana	625 Mali	771 Portuguese Timor
219 Cape Verde	414 Gibraltar	627 Malta	
104 Cayman Islands	418 Greece	086 Mariana Islands	772 Qatar
225 Central African Republic	420 Greenland	080 Marshall Islands	773 Reunion

## COUNTRY CODE LIST (continued)

781 Romania	823 Sierra Leone	875 Syria	924 Uruguay
148 Ross Dependency	496 Sikkim	244 Taiwan	928 Uzbekistan
785 Russia	825 Singapore	882 Tajikistan	930 Vanuatu
790 Rwanda	967 Slovak Republic	880 Tanzania	932 Vatican City
573 Ryukyu Islands	826 Slovenia	891 Thailand	935 Venezuela
662 Saba	828 Solomon Islands	893 Togo	941 Viet Nam
663 Saint Eustatius	830 Somalia	149 Tokelau	054 Virgin Islands
793 Saint Helena & Dependencies	836 South Africa	892 Tonga	092 Wake Island
661 Saint Kitts & Nevis	150 South Georgia	894 Trinidad and Tobago	948 Wales
306 Saint Lucia	583 South Korea	895 Tunisia	146 Wallis and Futuna
666 Saint Maarten	151 South Sandwich Islands	902 Turkey	411 West Germany
395 Saint Martin	153 South Vietnam	903 Turkmenistan	158 Western Sahara
142 Saint Pierre and Miquelon	953 South Yemen	106 Turks and Caicos Islands	795 Western Samoa
794 Saint Vincent and The Grenadines	847 Spain	904 Tuvalu	951 Yemen
798 San Marino	220 Sri Lanka	099 USA	957 Yugoslavia
796 Sao Tome and Principe	000 Stateless	913 USSR	266 Zaire
797 Saudi Arabia	848 Sudan	905 Uganda	965 Zambia
947 Scotland	850 Suriname	908 Ukraine	775 Zimbabwe
820 Senegal	855 Swaziland	916 United Arab Emirates	
821 Serbia	858 Sweden	917 United Kingdom	
822 Seychelles	869 Switzerland	999 Unknown	

## GRADUATE MEDICAL EDUCATION PROGRAM CODE LIST (ALPHABETICAL)

Use only for Item 9.

31 Anesthesiology	35 Neurology	28 Pediatrics	42 Radiology – Diagnostic
32 Dermatology	36 Nuclear Medicine	40 Physical Medicine & Rehabilitation	43 Radiology – Therapeutic
33 Emergency Medicine	23 Obstetrics/Gynecology	49 Plastic Surgery	19 Surgery
20 Family Practice	37 Ophthalmology	47 Preventive Medicine/ Public Health	14 Transitional
16 Internal Medicine	38 Orthopedic Surgery	41 Psychiatry	44 Urology
30 Medicine – Pediatrics	39 Otolaryngology		
34 Neurological Surgery	25 Pathology		

## SPECIALTY CODE LIST (ALPHABETICAL)

Use only for Item 10.

01 Allergy & Immunology	42 Medical Genetics	14 Otolaryngology	20 Psychiatry
02 Anesthesiology	08 Neurological Surgery	15 Pathology	21 Radiology
03 Colon & Rectal Surgery	09 Neurology	16 Pediatrics	22 Surgery
04 Dermatology	10 Nuclear Medicine	17 Physical Medicine & Rehabilitation	23 Thoracic Surgery
05 Emergency Medicine	11 Obstetrics & Gynecology	18 Plastic Surgery	24 Urology
06 Family Practice	12 Ophthalmology	19 Preventative Medicine	
07 Internal Medicine	13 Orthopedic Surgery		

## OSTEOPATHIC (DO) SPECIALTY CODES (ALPHABETICAL)

43 Allergy & Immunology	28 General Practice	33 Ophthalmology & Otorhinolaryngology	37 Preventative Medicine
25 Anesthesiology	29 Internal Medicine	34 Orthopedic Surgery	38 Proctology
26 Dermatology	30 Neurology & Psychiatry	35 Pathology	39 Radiology
27 Emergency Medicine	31 Nuclear Medicine	36 Pediatrics	40 Rehabilitation Medicine
44 Family Medicine	32 Obstetrics & Gynecology		41 Surgery

**UNITED STATES MEDICAL LICENSING EXAMINATION™ (USMLE™)  
2010 STEP 3 APPLICATION**

For applications submitted to FSMB by September 3, 2010

Refer to the Application Instructions when completing this form. Complete all three pages. Type or print in uppercase block letters. Use black ink only.

<p><b>1. STATE MEDICAL BOARD</b> See Instructions for Board Code.</p>	<table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 10%; text-align: center;"> </td> <td style="border: 1px solid black; width: 10%; text-align: center;"> </td> <td style="border: 1px solid black; width: 10%; text-align: center;"> </td> <td style="border: none; padding-left: 10px;">Name of state medical board whose requirements you are using to apply for Step 3.</td> </tr> </table>				Name of state medical board whose requirements you are using to apply for Step 3.																																
			Name of state medical board whose requirements you are using to apply for Step 3.																																		
<p><b>2. FEE ENCLOSED</b> See State Specific Instruction Sheet for fee.</p>	<p>\$ _____ <b>U.S. DOLLARS (non-refundable fee)</b></p>																																				
<p><b>3. NAME</b> Print your name exactly as it appears on the unexpired, government-issued identification you plan to present at the test center. See Instructions, "Completing Your Application."</p>	<table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 100%; height: 20px;"> </td> <td style="border: none; padding-left: 5px;"><b>LAST</b> (Surname) and Suffix</td> </tr> <tr> <td style="border: 1px solid black; width: 100%; height: 20px;"> </td> <td style="border: none; padding-left: 5px;"><b>FIRST</b> and Middle Name(s)</td> </tr> </table> <p>If you have applied previously under another name for any examination, please provide a copy of a non-expired, government issued document bearing your new name, signature and photograph (e.g., driver's license or passport).</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">Last <span style="margin-left: 200px;">First</span></p>		<b>LAST</b> (Surname) and Suffix		<b>FIRST</b> and Middle Name(s)																																
	<b>LAST</b> (Surname) and Suffix																																				
	<b>FIRST</b> and Middle Name(s)																																				
<p><b>4. DATE OF BIRTH</b> Indicate month, day and year as numbers.</p>	<table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;">1</td> <td style="border: 1px solid black; width: 15%; text-align: center;">9</td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> </tr> <tr> <td style="border: none; text-align: center;">MONTH</td> <td style="border: none; text-align: center;">DAY</td> <td colspan="4" style="border: none; text-align: center;">YEAR</td> </tr> </table>			1	9			MONTH	DAY	YEAR																											
		1	9																																		
MONTH	DAY	YEAR																																			
<p><b>5. U.S. SOCIAL SECURITY AND NATIONAL IDENTIFICATION NUMBERS (optional)</b> Enter your S.S. Number and/or the official number assigned by your country if outside the U.S. See Instructions for Country Code.</p>	<table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> </tr> <tr> <td colspan="6" style="border: none; text-align: center;">U.S. Social Security Number</td> </tr> <tr> <td style="border: 1px solid black; width: 100%; height: 20px;"> </td> <td colspan="5" style="border: none;"></td> </tr> <tr> <td colspan="6" style="border: none; text-align: center;">National Identification Number</td> </tr> <tr> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> </tr> <tr> <td style="border: none; text-align: center;">Country Code</td> <td colspan="5" style="border: none; text-align: center;">Issuing Country</td> </tr> </table>							U.S. Social Security Number												National Identification Number												Country Code	Issuing Country				
U.S. Social Security Number																																					
National Identification Number																																					
Country Code	Issuing Country																																				
<p><b>6. GENDER</b></p>	<p><input type="checkbox"/> Male      <input type="checkbox"/> Female</p>																																				
<p><b>7. CITIZENSHIP UPON ENTERING MEDICAL SCHOOL</b> See Instructions for Country Code.</p>	<table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: none; padding-left: 10px;">Name of Country</td> </tr> </table>				Name of Country																																
			Name of Country																																		
<p><b>8. MEDICAL EDUCATION</b> See Instructions for Country Code.</p> <p>Graduation Date - Indicate month and year as numbers.</p>	<p>Medical School of Graduation _____</p> <table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: none; padding-left: 10px;">City, Country of Medical School</td> <td style="border: none; padding-left: 20px;">Graduation Date</td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> <td style="border: 1px solid black; width: 15%; text-align: center;"> </td> </tr> <tr> <td style="border: none; text-align: center;">Country Code</td> <td colspan="3" style="border: none;"></td> <td style="border: none; text-align: center;">MONTH</td> <td colspan="4" style="border: none; text-align: center;">YEAR</td> </tr> </table> <p>Degree:    <input type="checkbox"/> M.D.    <input type="checkbox"/> D.O.    <input type="checkbox"/> Other (specify): _____</p> <p>If school is outside the U.S. or Canada:    ECFMG Certified:    <input type="checkbox"/> Yes    <input type="checkbox"/> No    If yes, date issued:    ____/____/____</p> <p style="text-align: right; margin-right: 100px;">MO    DY    YR</p> <p style="text-align: right; margin-right: 100px;">5th Pathway Program:    <input type="checkbox"/> Yes    <input type="checkbox"/> No    If yes, date completed:    ____/____/____</p> <p style="text-align: right; margin-right: 100px;">MO    DY    YR</p> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 30%;"><b>FOR OFFICE USE ONLY</b></td> <td style="width: 20%;"><b>SCC</b></td> <td style="width: 10%;"><b>Y</b></td> <td style="width: 10%;"><b>N</b></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> <tr> <td><b>DEGREE</b></td> <td><b>Y</b></td> <td><b>N</b></td> <td><b>5th PATHWAY</b></td> <td><b>Y</b></td> <td><b>N</b></td> </tr> <tr> <td><b>ECFMG</b></td> <td><b>Y</b></td> <td><b>N</b></td> <td><b>EXAM PREREQUISITES</b></td> <td><b>Y</b></td> <td><b>N</b></td> </tr> </table>				City, Country of Medical School	Graduation Date					Country Code				MONTH	YEAR				<b>FOR OFFICE USE ONLY</b>	<b>SCC</b>	<b>Y</b>	<b>N</b>			<b>DEGREE</b>	<b>Y</b>	<b>N</b>	<b>5th PATHWAY</b>	<b>Y</b>	<b>N</b>	<b>ECFMG</b>	<b>Y</b>	<b>N</b>	<b>EXAM PREREQUISITES</b>	<b>Y</b>	<b>N</b>
			City, Country of Medical School	Graduation Date																																	
Country Code				MONTH	YEAR																																
<b>FOR OFFICE USE ONLY</b>	<b>SCC</b>	<b>Y</b>	<b>N</b>																																		
<b>DEGREE</b>	<b>Y</b>	<b>N</b>	<b>5th PATHWAY</b>	<b>Y</b>	<b>N</b>																																
<b>ECFMG</b>	<b>Y</b>	<b>N</b>	<b>EXAM PREREQUISITES</b>	<b>Y</b>	<b>N</b>																																
<p><b>9. POSTGRADUATE MEDICAL EDUCATION IN U.S. OR CANADA</b> Check one box only.</p>	<p><input type="checkbox"/> I have not participated in a graduate medical education program.</p> <p><input type="checkbox"/> I will begin a graduate medical education program on ____/____.</p> <p style="text-align: center; margin-left: 100px;">MO    YR</p> <p><input type="checkbox"/> I am currently serving in my first year graduate medical education program which began on ____/____.</p> <p style="text-align: center; margin-left: 100px;">MO    YR</p> <p><input type="checkbox"/> I have completed satisfactorily ____ year(s) in a graduate medical education program from ____/____ to ____/____.</p> <p style="text-align: center; margin-left: 100px;">MO    YR                      MO    YR</p> <p>Most recent program and hospital:</p> <table style="width:100%; border: none; margin-top: 10px;"> <tr> <td style="border: 1px solid black; width: 10%; text-align: center;"> </td> <td style="border: 1px solid black; width: 10%; text-align: center;"> </td> <td style="border: none; padding-left: 10px;">Program Name</td> </tr> <tr> <td colspan="3" style="border: none; height: 20px;"> </td> </tr> <tr> <td colspan="3" style="border: none; text-align: center;">Hospital Name</td> </tr> <tr> <td colspan="3" style="border: none; height: 20px;"> </td> </tr> <tr> <td colspan="3" style="border: none; text-align: center;">City</td> </tr> <tr> <td colspan="3" style="border: none; height: 20px;"> </td> </tr> <tr> <td style="border: none; text-align: center;">Program Code</td> <td style="border: none; text-align: center;">Program Director's Name</td> <td style="border: none; text-align: center;">E-mail</td> <td style="border: none; text-align: center;">Phone</td> </tr> </table>			Program Name				Hospital Name						City						Program Code	Program Director's Name	E-mail	Phone														
		Program Name																																			
Hospital Name																																					
City																																					
Program Code	Program Director's Name	E-mail	Phone																																		



UNITED STATES MEDICAL LICENSING EXAMINATION™

2010 STEP 3 APPLICATION

CERTIFICATION OF IDENTITY

This form must be signed by a notary public/commissioner of oaths. When completed and submitted to the Federation, this form becomes part of your USMLE record and will be used to identify you when you interact with the Federation if you need to re-apply for the Step 3.

This Certification of Identity is valid for this and any subsequent Step 3 application(s) submitted to the Federation within a period of five years from the date of the applicant's signature. If you do not sit for this administration of Step 3 or must retake Step 3, it is not necessary to submit another Certification of Identity as long as this form is on file with the Federation of State Medical Boards and has not expired.

USMLE IDENTIFICATION NO. [ ]-[ ]-[ ]-[ ]-[ ]-[ ]-[ ]-[ ]-[ ]-[ ]

Type or print in uppercase block letters. Use black ink only.

ATTACH PHOTO HERE
Securely tape or glue in this square a current front-view 2" x 2" color or passport quality photo (Print full name on back of photo before attaching).

Name:

Last First Middle

S.S./N.I. Number (Optional) Date of Birth (Month/Day/Year) Gender Male Female

State Medical Board for which Step 3 is being taken:

I certify that I am the individual named above, represented in the attached photograph and that the signature below is my signature. I certify that I meet the eligibility requirements for Step 3 and that the information on this form is true and accurate. I also certify that I have read the most current version of the USMLE Bulletin of Information and all relevant instructions for this or any subsequent Step 3 application, that I am familiar with the contents of the Bulletin and agree to abide by the policies and procedures described therein. I authorize the release of my USMLE history to the medical licensing authority for which I am taking Step 3 and agree that my subsequent Step 3 score may also be released to the medical licensing authority.

Applicant's Signature

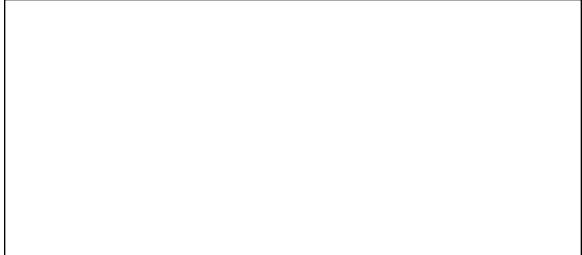
CERTIFICATION OF IDENTIFICATION
Certification by Notary Public Is Required

State of County of

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this day of Month Year.

Notary Public Signature

Commission Expiration Date\* (Month/Day/Year)



Notary stamp/seal here.

\*The notary's commission expiration date must be current and legible. If no expiration date, such as "lifetime," an explanation must be provided.