

NAME _____

10. SPECIALTY
See Instructions for Specialty Code. Use appropriate allopathic and/or osteopathic codes.

Specialty Code _____ Name of Specialty or Planned Specialty _____

11. USMLE OR ECFMG IDENTIFICATION NUMBER

Identification Number (If Known)

ECFMG - - -

USMLE - - -

12. ADDRESS

This address will be used for correspondence regarding registration for Step 3. Print your current mailing address.

If you provide an address outside the U.S., correspondence relating to Step 3 may be significantly delayed. Provide a U.S. address, if possible.

If your address changes see the Instructions "Change of Address."

See Instructions for Country Code.

***an e-mail address must be provided to complete the application and obtain a Scheduling Permit and Score Report.**

Address Line 1

Address Line 2

Address Line 3

City

State/Province

Country

Country Code

 -

ZIP/Postal Code

Daytime Telephone Number

E-mail address (required to obtain a scheduling permit and Score Report)

13. TEST ACCOMMODATIONS

Check this box if you are requesting test accommodations.

I have a documented disability covered under the American with Disabilities Act and am requesting test accommodations. **(Checking this box does not constitute an official request. You must submit your request for test accommodations and accompanying documentation at the same time as this application. See Instructions, "Applying for Test Accommodations.")**

14. DATA RELEASE

Release of Step 3 Data

The NBME reports USMLE total scores to LCME- and AOA-accredited medical schools for their students and graduates. This data is used by the schools to monitor the outcome of their educational process and as part of ongoing quality improvement activities. Only a total score is provided. If you do not wish to have your Step 3 score reported to your U.S. or Canadian medical school of graduation, please check the box provided to the left.

15. RACE/ETHNIC DATA

Provision of the following information is voluntary. The information will be used for research purposes only. You are encouraged to provide the information. The processing of your application will not be affected by your choice in this regard.

Select the one option which best describes your race/ethnicity.

11

American Indian/
Alaskan Native

12

Asian

13

Native Hawaiian or other
Pacific Islander

14

Hispanic or Latino

15

Black or African
American

16

White

17

Other

Is English your native language?

Yes

No

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.