

Request Form to Extend the USMLE Step 3 Eligibility Period
The Federation of State Medical Boards (FSMB) ~ 817-868-4041 ~ usmle@fsmb.org

This form must be mailed to one of the addresses below with the fee and PGT re-verification form (if applicable).

Applicant's Name: Last _____ First _____ MI _____

State for which you are registered to take Step 3: _____

USMLE ID# _____ Current Eligibility Period End Date* _____

Date of Birth _____ SS# (optional) or National ID# _____

Daytime Phone # _____ Email Address _____

****PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY****
All of the above fields must be completed in order to process this request.

1. Applicants requesting an eligibility period extension must mail this form with the \$55 processing fee in the form of a personal check or money order (payable to FSMB) to one of the addresses below.
2. *The Eligibility Period Extension Request Form **must be received in our office with the processing fee no later than 10 days after the expiration of the original eligibility period's end date. (No exceptions)**
3. At the time of the extension request, the FSMB will verify that the physician still meets USMLE and state medical board eligibility requirements for that state. This includes any time limits and/or any post graduate training requirements for Step 3.
 - a. For purposes of Step 3 eligibility, most state medical boards have a 7-year time limit to complete all USMLE Steps. Refer to the [state-specific instructions](#) for the state whose Step 3 application you completed to determine whether you are eligible for an eligibility extension based upon your examination history.
 - b. If you registered for Step 3 with [Colorado, Hawaii, Indiana, Iowa, Kentucky, Minnesota, New Hampshire, North Dakota, Oregon, Pennsylvania or Washington \(Allopathic\)](#), you may need to submit a new PGT form. Each of these states requires a minimum PGT prior to sitting Step 3. If you registered for one of these states and met their PGT requirement by virtue of being currently enrolled in a program rather than having completed the minimum months of PGT, you must complete a [new PGT form](#) and submit it along with this request form and fee. All three items must be received in order to process your request.
4. The processing fee accompanying this form is non-refundable.
5. **Mail this Form, PGT re-verification form (if applicable) and the fee to one of the following addresses:**

<p style="text-align: center;"><i>Via First Class US Postal Service ONLY</i> <i>Without tracking or signature required services:</i></p> <p style="text-align: center;">Attn: Wholesale Lockbox Exam Dept/Extension Request Federation of State Medical Boards P O Box 970172 Dallas, TX 75397-0172</p>	<p style="text-align: center;"><i>Via express tracking services for</i> <i>FedEx, Airborne, UPS or US Postal Service ONLY:</i></p> <p style="text-align: center;">Attn: Exam Dept/Extension Request Federation of State Medical Boards Suite 300 400 Fuller Wiser Road Eules, TX 76039 <i>No Saturday or Sunday deliveries accepted</i></p>
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I certify that I currently meet USMLE Step 3 and state medical board eligibility requirements and that the information provided on this form is true and accurate. I also certify that I have read the current *USMLE Bulletin of Information*, am familiar with its contents, and agree to abide by the policies and procedures described therein. I understand that I will receive a one-time-only 90-day extension of my eligibility period (per application) upon approval from the FSMB and that I will not be granted a further extension.

Applicant Signature _____ Date _____

Federation of State Medical Boards (FSMB)
PO Box 619850, Dallas, TX 75261-9850
Telephone (817) 868-4041

USMLE STEP 3
RE-VERIFICATION OF POST-GRADUATE TRAINING FOR EXTENSION OF ELIGIBILITY

Important: If you applied for USMLE Step 3 for any of the following states (Colorado, Hawaii, Indiana, Iowa, Kentucky, Minnesota, New Hampshire, North Dakota, Oregon, Pennsylvania, or Washington Medical), you should submit this completed form, along with your "Step 3 Eligibility Period Extension Request Form" and fee. This is required if you met the post-graduate training requirement by virtue of being currently enrolled in a program rather than the specified minimum number of months training.

Applicant completes this section.
(PLEASE PRINT)

USMLE ID # _____ Step 3 State Board _____ Date of Birth _____

Physician Name _____
(PLEASE PRINT- Last Name, First Name, Middle Name)

Hospital Name _____
(complete name of hospital or university)

City _____ State _____ Ph# _____

I hereby authorize the release of all pertinent information, favorable or otherwise, to FSMB.

X _____
Signature _____ Date _____

This section is to be completed by the Program Director. Applicant should forward both this form and the "Eligibility Period Extension Request Form" and fee to the lockbox address on the request form.

I certify that the physician named above remains a member in good standing of this residency program. ____ YES ____ NO
Use the space below if additional comments are necessary.

Printed Name of Program Director _____ Email Address _____ Ph# _____

X _____
Signature of Program Director _____ Date _____