

UNITED STATES MEDICAL LICENSING EXAMINATION™ (USMLE™) STEP 3

817-868-4041 ~ exam@fsmb.org

Questionnaire for USMLE Step 3 Applicants Requesting Test Accommodations

You must provide supporting documentation verifying your disability. The documentation must be from a qualified professional. Please refer to the Guidelines for Requesting Test Accommodations on our website: www.fsmb.org. Mail this completed Questionnaire form and documentation to the following address:

Attn: Supervisor of Examination Services
Federation of State Medical Boards
400 Fuller Wisser Road, Suite 300, Euless, TX 76039

Mail your Step 3 Application to the separate address shown in the Application Instructions located on the Federation's website at the same time you mail your request for test accommodations to the address above.

Please type or print.

- 1. a. I am submitting a USMLE Step 3 Application (the year is listed at the top of the Step 3 application).
b. I am applying for the USMLE Step 3 exam through the State of

2. Name: Last First Middle Initial

3. Gender: Male Female 4. Date of Birth

5. SS# 6. USMLE # (if known)

7. Address: Street

City State/Province Zip/Postal Code

Country Area Code Daytime Telephone Number

Email Address: (Listing an Email address will expedite correspondences)

8. Medical School of Graduation
Country of Medical School

- 9. Nature of the Disability:
Hearing Disability Psychiatric Disability
Learning Disability Visual Disability
Physical Disability Other

10. In order to document your need for accommodation as completely as possible, please attach, in addition to professional documentation, a personal statement describing your disability and its impact on your daily life and educational functioning. Do not confine your comments to standardized test performance; rather discuss your overall functioning.

11. How long ago was your disability first professionally diagnosed?

- less than 1 year 1-2 years 2-4 years 5 or more years

12. What accommodation(s) are you requesting? Accommodation(s) must be appropriate to the disability (be specific). \_\_\_\_\_  
\_\_\_\_\_

13. If you are requesting Extended Testing Time **OR** Additional Break Time, please indicate below, as supported by your documentation. **(YOU MUST SELECT ONLY ONE OF THE FOLLOWING BOXES):**

**Extended Testing Time**

- Time and one half (Three Day Schedule)  
 Double Testing Time (Four Day Schedule)

**Additional Break Time**

- Extra Break Time - Two Day Schedule  
 Extra Break Time - Four Day Schedule

14. Do you require wheelchair access at the examination facility?  Yes  No  
**If you require an adjustable height table, please indicate the number of inches from the floor. \_\_\_\_ inches**

15. Prior classroom or test accommodations that you have received:

A. Standardized Examinations

- Medical College Admission Test (MCAT) Month/Year \_\_\_\_\_  
Accommodation received \_\_\_\_\_  
(If extra time, note amount given \_\_\_\_\_)  
 Other(specify) \_\_\_\_\_ Month/Year \_\_\_\_\_  
Accommodation received \_\_\_\_\_  
(if extra time, note amount given \_\_\_\_\_)

B. Medical School

- Yes  No

Accommodation received \_\_\_\_\_  
Date approved (mo/day/yr) \_\_\_\_\_

**If yes, have an appropriate official at your medical school complete the *Certification of Prior Test Accommodation* form from the USMLE CD or the website: [www.fsmb.org](http://www.fsmb.org).**

C. College

- Yes  No

If yes, accommodation received: \_\_\_\_\_

D. Secondary or elementary school

- Yes  No

If yes, accommodation received: \_\_\_\_\_

16. Certification/Authorization:

I certify that the above information is true and accurate. If clarification or further information regarding the documentation provided is needed, I authorize the USMLE Disability Services and/or the Federation of State Medical Boards (FSMB) to contact the professional(s) who diagnosed the disability and/or those entities which have granted me test accommodations. I authorize such professional(s) and entities to communicate with the USMLE Disability Services or FSMB in this regard to provide the FSMB with such clarification and/or further information. I authorize the release of any documentation/information relating to my current or any prior request(s) for testing accommodations made by me in connection with USMLE Step(s) to the USMLE Disability Services and their consultants, and to the medical licensing authority, through which I am applying to take Step 3.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Mail this form to the address above, attention to the Supervisor of Examination Services  
(Submitting this form constitutes your official request)