Introduction

The United States Medical Licensing Examination Program provides reasonable and appropriate accommodations in accordance with the Americans with Disabilities Act for individuals with documented disabilities who demonstrate a need for accommodation. Examinees are informed of the availability of test accommodations in the USMLE Bulletin of Information: Applying and Scheduling and in the Application Instructions. The following information is provided for examinees, evaluators, medical school student affairs staff, faculty and others involved in the process of documenting a request for test accommodations. Applicants requesting test accommodations should share these guidelines with their evaluator, therapist, treating physician, etc., so that appropriate documentation can be assembled to support the request for test accommodations. The Americans with Disabilities Act of 1990 (ADA) and accompanying regulations define a person with a disability as someone with a physical or mental impairment that substantially limits one or more major life activities such as walking, seeing, hearing, or learning. The purpose of documentation is to validate that the individual is covered under the Americans with Disabilities Act as a disabled individual. The purpose of accommodations is to provide equal access to the USMLE testing program. Accommodations "match up" with the identified functional limitation so that the area of impairment is alleviated by an auxiliary aid or adjustment to the testing procedure. Functional limitation refers to the behavioral manifestations of the disability that impede the individual's ability to function, i.e., what someone cannot do on a regular and continuing basis as a result of the disability. For example, a functional limitation might be impaired vision so that the individual is unable to view the examination in the standard font size. An appropriate accommodation might be text enlargement. It is essential that the documentation provide a clear explanation of the functional impairment and a rationale for the requested accommodation. While presumably the use of accommodations in the test activity will enable the individual to better demonstrate his/her knowledge mastery, accommodations are not a guarantee of improved performance, test completion or a passing score.

Overview and Instructions

To Request Test Accommodations:

1. Read the Guidelines carefully. Share them with the professional who will be helping you prepare your documentation.
2. Read the instructions for completing the Request for Test Accommodations form.
3. Complete and sign the appropriate request form.
4. If appropriate, have your medical school complete the Certification of Prior Test Accommodations form.
5. Attach documentation of the disability and your need for accommodation.
   - Compare your documentation with the information listed in these guidelines to ensure a complete submission.
   - Incomplete documentation will delay processing of your request.
6. Send your request for test accommodations and supporting documentation to the appropriate registration entity as noted on the form.

**Test Accommodations**

Test accommodations include but are not limited to the following:

- Assistance with keyboard tasks
- Audio rendition
- Extended testing time
- Additional break time
- Enlarged text and graphics
- Permission for assistive devices

**Score Reporting**

When test accommodations are granted for USMLE Steps and Step Components, score reports and transcripts may include an annotation that an accommodation was granted. Score recipients who inquire about the annotation will be provided with information about the nature of the test accommodation only.

**General Guidelines for all Disabilities**

The following guidelines are provided to assist the applicant in documenting a need for accommodation based on an impairment that substantially limits one or more major life activities. Documentation submitted in support of a request may be referred to experts in the appropriate area of disability for a fair and impartial professional review. The examinee must personally initiate a written request for accommodations or for release of information relative to an accommodations request. All documentation submitted in support of a request for accommodations is confidential. No information concerning a request for accommodations is released without a written request from the examinee. Accommodations requests by a third party (such as an evaluator or medical school) cannot be honored.

**To support a request for test accommodations, please submit the following:**

1. Completed Test Accommodations Request form.
2. A detailed, comprehensive written report describing your disability and its severity and justifying the need for the requested accommodations.
3. The following characteristics are expected of all documentation submitted in support of a request for accommodations. **Documentation must:**
   - state a specific diagnosis of the disability.
     A professionally recognized diagnosis for the particular category of disability is expected, e.g., the DSM-IV diagnostic categories for learning disorders.
   - be current.
     Because the provision of reasonable accommodations is based on assessment of the current impact of the examinee's disability on the testing activity, it is in the individual's best interest to provide recent documentation. As the manifestations of a disability may vary over
time and in different settings, in most cases an evaluation should have been conducted within the past three years, e.g., visual or neuromuscular conditions are often subject to change and should be updated for current functioning.

- **describe the specific diagnostic criteria and name the diagnostic tests used, including date(s) of evaluation, specific test results and a detailed interpretation of the test results.** This description should include the results of diagnostic procedures and tests utilized and should include relevant educational, developmental, and medical history. Specific test results should be reported to support the diagnosis, e.g., documentation for an examinee with multiple sclerosis should include specific findings on the neurological examination including functional limitations and MRI or other studies, if relevant.

Diagnostic methods used should be appropriate to the disability and current professional practices within the field. Informal or non-standardized evaluations should be described in enough detail that other professionals could understand their role and significance in the diagnostic process.

- **describe in detail the individual's limitations due to the diagnosed disability, i.e., a demonstrated impact on functioning vis-a-vis the USMLE and explain the relationship of the test results to the identified limitations resulting from the disability.** The current functional impact on physical, perceptual and cognitive abilities should be fully described, e.g., an examinee with macular degeneration has reduced central vision which limits the ability to read.

- **recommend specific accommodations and/or assistive devices including a detailed explanation of why these accommodations or devices are needed and how they will reduce the impact of the identified functional limitations, e.g., a learning disabled individual who has difficulty decoding might require an audio rendition of the exam.**

- **establish the professional credentials of the evaluator that qualify him/her to make the particular diagnosis, including information about license or certification and specialization in the area of the diagnosis.** The evaluator should present evidence of comprehensive training and direct experience in the diagnosis and treatment of adults in the specific area of disability.

If no prior accommodations have been provided, the qualified professional expert should include a detailed explanation as to why no accommodations were given in the past and why accommodations are needed now.
Learning Disorders

Documentation for applicants submitting a request for accommodations based on a learning disorder or other cognitive impairment should contain all of the items listed in the General Guidelines section. The following information explains the additional issues documentation must address relative to learning disorders.

- The evaluation must be conducted by a qualified professional. The diagnostian must have comprehensive training in the field of learning disorders and must have comprehensive training and direct experience in working with an adult population.

- Testing/assessment must be current. The determination of whether an individual is substantially limited in functioning according to Americans with Disabilities Act (ADA) criteria is based on assessment of the current impact of the impairment. (See General Guidelines). A developmental disorder such as a learning disorder originates in childhood and, therefore, information which demonstrates a history of impaired functioning should also be provided.

- Documentation must be comprehensive. Objective evidence of a substantial limitation in cognition or learning must be provided. At a minimum, the comprehensive evaluation should include the following:

  1. **A diagnostic interview and history taking**
     Because learning disorders are commonly manifested during childhood, though not always formally diagnosed, relevant historical information regarding the individual's academic history and learning processes in elementary, secondary and postsecondary education should be investigated and documented. The report of assessment should include a summary of a comprehensive diagnostic interview that includes relevant background information to support the diagnosis. In addition to the candidate's self-report, the report of assessment should include:

     - A description of the presenting problem(s);
     - A developmental history;
     - Relevant academic history including results of prior standardized testing, reports of classroom performance and behaviors including transcripts, study habits and attitudes and notable trends in academic performance;
     - Relevant family history, including primary language of the home and current level of fluency in English;
     - Relevant psychosocial history;
     - Relevant medical history including the absence of a medical basis for the present symptoms;
     - Relevant employment history;
     - A discussion of dual diagnosis, alternative or co-existing mood, behavioral, neurological and/or personality disorders along with any history of relevant medication and current use that may impact the individual's learning; and
     - Exploration of possible alternatives that may mimic a learning disorder when, in fact, one is not present
     - A psychoeducational or neuropsychological evaluation
• The psychoeducational or neuropsychological evaluation must be submitted on the letterhead of a qualified professional and it must provide clear and specific evidence that a learning or cognitive disability does or does not exist.
• Assessment must consist of a comprehensive battery of tests.
• A diagnosis must be based on the aggregate of test results, history and level of current functioning. It is not acceptable to base a diagnosis on only one or two subtests.
• Objective evidence of a substantial limitation to learning must be presented.
• Tests must be appropriately normed for the age of the patient and must be administered in the designated standardized manner.

2. **Cognitive Functioning**
   A complete cognitive assessment is essential with all subtests and standard scores reported. Acceptable measures include but are not limited to: Wechsler Adult Intelligence Scale-IV (WAIS-IV); Woodcock Johnson Psychoeducational Battery-III (WJ-III): Tests of Cognitive Ability; Kaufman Adolescent and Adult Intelligence Test.

3. **Achievement**
   A comprehensive achievement battery with all subtests and standard scores is essential. The battery must include current levels of academic functioning in relevant areas such as reading (decoding and comprehension) and mathematics. Acceptable instruments include, but are not limited to, the Woodcock-Johnson Psychoeducational Battery-III (WJ-III): Tests of Achievement; The Scholastic Abilities Test for Adults (SATA); Woodcock Reading Mastery Tests-III (WRMT). Specific achievement tests are useful instruments when administered under standardized conditions and when interpreted within the context of other diagnostic information. The Wide Range Achievement Test 4 (WRAT4) and the Nelson-Denny Reading Test are not comprehensive diagnostic measures of achievement and therefore neither is acceptable if used as the sole measure of achievement.

4. **Information Processing**
   Specific areas of information processing (e.g., short- and long-term memory, sequential memory, auditory and visual perception/processing, auditory and phonological awareness, processing speed, executive functioning, motor ability) must be assessed. Acceptable measures include, but are not limited to, the Detroit Tests of Learning Aptitude - Adult (DTLA-A), Wechsler
Memory Scale-IV (WMS-IV), information from the Woodcock Johnson Psychoeducational Battery-III (WJ-III): Tests of Cognitive Ability, as well as other relevant instruments that may be used to address these areas.

5. **Other Assessment Measures**
Other formal assessment measures or nonstandard measures and informal assessment procedures or observations may be integrated with the above instruments to help support a differential diagnosis or to disentangle the learning disability from co-existing neurological and/or psychiatric issues. In addition to standardized test batteries, nonstandardized measures and informal assessment procedures may be helpful in determining performance across a variety of domains.

6. **Actual test scores must be provided (standard scores where available).**
Evaluators should use the most recent form of tests and should identify the specific test form as well as the norms used to compute scores. It is helpful to list all test data in a score summary sheet appended to the evaluation. Age norms where available should be provided.

7. **Records of academic history should be provided.**
Because learning disorders are most commonly manifested during childhood, relevant records detailing learning processes and difficulties in elementary, secondary and postsecondary education should be included. Such records as grade reports, transcripts, teachers' comments and the like will serve to substantiate self-reported academic difficulties in the past and currently.

8. **Provide score reports for standardized tests**
(e.g., SAT, ACT, GRE, GMAT, MCAT) and indicate which, if any, accommodations were provided.

9. **A differential diagnosis must be reviewed and various possible alternative causes for the identified problems in academic achievement should be ruled out.**
The evaluation should address key constructs underlying the concept of learning disorders and provide clear and specific evidence of the information processing deficit(s) and how these
deficits currently impair the individual's ability to learn. No single test or subtest is a sufficient basis for a diagnosis.

The differential diagnosis must demonstrate that:

- Significant difficulties persist in the acquisition and use of listening, speaking, reading, writing or reasoning skills.
- The problems being experienced are not primarily due to lack of exposure to the behaviors needed for academic learning or to an inadequate match between the individual's ability and the instructional demands.

10. **A clinical summary must be provided.**
A well-written diagnostic summary based on a comprehensive evaluative process is a necessary component of the report. Assessment instruments and the data they provide do not diagnose; rather, they provide important data that must be integrated with background information, historical information and current functioning. It is essential then that the evaluator integrate all information gathered in a well-developed clinical summary.

The following elements must be included in the clinical summary:

- Demonstration of the evaluators having ruled out alternative explanations for the identified academic problems as a result of poor education, poor motivation and/or study skills, emotional problems, attentional problems and cultural or language differences;
- Indication of how patterns in cognitive ability, achievement and information processing are used to determine the presence of a learning disability;
- Indication of the substantial limitation to learning presented by the learning disability and the degree to which it impacts the individual in the context of the USMLE; and
- Indication as to why specific accommodations are needed and how the effects of the specific disability are alleviated by the recommended accommodation(s).

Problems such as test anxiety, English as a second language (in and of itself), slow reading without an identified underlying cognitive deficit or failure to achieve a desired academic outcome are not learning disorders and therefore are not covered under the Americans with Disabilities Act.

11. **Each accommodation recommended by the evaluator must include a rationale.**
The evaluator must describe the impact the diagnosed learning disability has on a specific major life activity as well as the degree of significance of this impact on the individual. The diagnostic report must include specific recommendations for accommodations and a detailed explanation as to why each accommodation is recommended. Recommendations must be tied to specific test results or clinical observations. The documentation should include any record of prior accommodation or auxiliary aids, including any information about specific conditions under which the accommodations were used and whether or not they were effective. However, a prior history of accommodation, without demonstration of a current need, does not in and of itself warrant the provision of a like accommodation. If no prior accommodation(s) has been provided, the qualified professional expert should include a detailed explanation as to why no accommodation(s) was used in the past and why accommodation(s) is needed at this time.

### Attention-Deficit/Hyperactivity Disorder (ADHD)

Documentation for applicants submitting a request for accommodations based on an Attention-Deficit/Hyperactivity Disorder (ADHD) should contain all of the items listed in the General Guidelines section. The following information explains the additional issues documentation must address relative to ADHD.

1. **The evaluation must be conducted by a qualified diagnostician.**
   Professionals conducting assessments and rendering diagnoses of ADHD must be qualified to do so. Comprehensive training in the differential diagnosis of ADHD and other psychiatric disorders and direct experience in diagnosis and treatment of adults is necessary. The evaluator's name, title and professional credentials, including information about license or certification as well as the area of specialization, employment and state in which the individual practices should be clearly stated in the documentation.

2. **Testing/assessment must be current.**
   The determination of whether an individual is "substantially limited" in functioning is based on assessment of the current impact of the impairment on the USMLE testing program. See General Guidelines.

3. **Documentation necessary to substantiate the Attention-Deficit/Hyperactivity Disorder must be comprehensive.**
   Because ADHD is, by definition, first exhibited in childhood (although it may not have been formally diagnosed) and in more than one setting,
objective, relevant, historical information is essential. Information verifying a chronic course of ADHD symptoms from childhood through adolescence to adulthood, such as educational transcripts, report cards, teacher comments, tutoring evaluations, job assessments and the like are necessary.

1. The evaluator is expected to review and discuss DSM-IV diagnostic criteria for ADHD and describe the extent to which the patient meets these criteria. The report must include information about the specific symptoms exhibited and document that the patient meets criteria for long-standing history, impairment and pervasiveness.

2. A history of the individual's presenting symptoms must be provided, including evidence of ongoing impulsive/hyperactive or inattentive behaviors (as specified in DSM-IV) that significantly impair functioning in two or more settings.

3. The information collected by the evaluator must consist of more than self-report. Information from third party sources is critical in the diagnosis of adult ADHD. Information gathered in the diagnostic interview and reported in the evaluation should include, but not necessarily be limited to, the following:

   - History of presenting attentional symptoms, including evidence of ongoing impulsive/hyperactive or inattentive behavior that has significantly impaired functioning over time;
   - Developmental history;
   - Family history for presence of ADHD and other educational, learning, physical or psychological difficulties deemed relevant by the examiner;
   - Relevant medical and medication history, including the absence of a medical basis for the symptoms being evaluated;
   - Relevant psychosocial history and any relevant interventions;
   - A thorough academic history of elementary, secondary and postsecondary education;
   - Review of psychoeducational test reports to determine if a pattern of strengths or weaknesses is supportive of attention or learning problems;
   - Evidence of impairment in several life settings (home, school, work, etc.) and evidence that the disorder significantly restricts one or more major life activities.
   - Relevant employment history;
   - Description of current functional limitations relative to an educational setting and to USMLE in particular that are presumably a direct result of the described problems with attention;
• A discussion of the differential diagnosis, including alternative or co-existing mood, behavioral, neurological and/or personality disorders that may confound the diagnosis of ADHD;
• Exploration of possible alternative diagnoses that may mimic ADHD; and
• Age norms where available

4. Relevant Assessment Batteries
A neuropsychological or psychoeducational assessment may be necessary in order to determine the individual's pattern of strengths or weaknesses and to determine whether there are patterns supportive of attention problems. Test scores or subtest scores alone should not be used as the sole basis for the diagnostic decision. Scores from subtests on the Wechsler Adult Intelligence Scale - IV (WAIS - IV), memory functions tests, attention or tracking tests or continuous performance tests do not in and of themselves establish the presence or absence of ADHD. They may, however, be useful as one part of the process in developing clinical hypotheses. Checklists and/or surveys can serve to supplement the diagnostic profile but by themselves are not adequate for the diagnosis of ADHD. When testing is used, standard scores must be provided for all normed measures.

5. Identification of DSM-IV Criteria
A diagnostic report must include a review of the DSM-IV criteria for ADHD both currently and retrospectively and specify which symptoms are present (see DSM-IV for specific criteria). According to DSM-IV, "the essential feature of ADHD is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development." Other criteria include:
• Symptoms of hyperactivity-impulsivity or inattention that cause impairment that were present in childhood.
• Current symptoms that have been present for at least the past six months.
• Impairment from the symptoms present in two or more settings (school, work, home).

Documentation Must Include a Specific Diagnosis
The report must include a specific diagnosis of ADHD based on the DSM-IV diagnostic criteria. Individuals who report problems with organization, test anxiety, memory and concentration only on a situational basis do not fit the prescribed diagnostic criteria for ADHD. Given that many individuals benefit from prescribed medications and therapies, a positive response to medication by itself is not supportive of a diagnosis, nor does the use of medication in and of itself either support or negate the need for accommodation.
A Clinical Summary Must Be Provided
A well-written diagnostic summary based on a comprehensive evaluative process is a necessary component of the assessment. The clinical summary must include:

- Demonstration of the evaluators having ruled out alternative explanations for inattentiveness, impulsivity, and/or hyperactivity as a result of psychological or medical disorders or non-cognitive factors;
- Indication of how patterns of inattentiveness, impulsivity and/or hyperactivity across the life span and across settings are used to determine the presence of ADHD;
- Indication of the substantial limitation to learning presented by ADHD and the degree to which it impacts the individual in the context for which accommodations are being requested (e.g., impact on the USMLE program); and
- Indication as to why specific accommodations are needed and how the effects of ADHD symptoms, as designated by the DSM-IV, are alleviated by the accommodation(s).

Each accommodation recommended by the evaluator must include a rationale.
The evaluator must describe the impact of ADHD (if one exists) on a specific major life activity as well as the degree of significance of this impact on the individual. The diagnostic report must include specific recommendations for accommodations. A detailed explanation must be provided as to why each accommodation is recommended and should be correlated with specific identified functional limitations. Prior documentation may have been useful in determining appropriate services in the past. However, documentation should validate the need for accommodation based on the individual's current level of functioning. The documentation should include any record of prior accommodation or auxiliary aid, including information about specific conditions under which the accommodation was used (e.g., standardized testing, final exams, NBME subject exams, etc.). However, a prior history of accommodation without demonstration of a current need does not in itself warrant the provision of a similar accommodation. If no prior accommodation has been provided, the qualified professional and/or individual being evaluated should include a detailed explanation as to why no accommodation was used in the past and why accommodation is needed at this time.

Because of the challenge of distinguishing ADHD from normal developmental patterns and behaviors of adults, including procrastination, disorganization, distractibility, restlessness, boredom, academic underachievement or failure, low self-esteem and chronic tardiness or inattendance, a multifaceted evaluation must address the intensity and frequency of the symptoms and whether these behaviors constitute an impairment in a major life activity.
In addition to the General Guidelines for all disabilities, the following information is provided to assist the applicant in documenting a need for accommodation based on a visual impairment.

Comprehensive evaluation reports of visual functioning should include:

- A detailed discussion of how the individual's specific signs, symptoms, and assessment results meet professionally recognized diagnostic criteria for the identified visual impairment. Relevant history and course of the presenting symptoms should be provided and the documentation should identify whether the condition is stable or could be expected to fluctuate. The individual's best corrected visual acuities, for both distance and near, must be specified. Where relevant to the diagnosis, comprehensive documentation should also include detailed information about the health of the eye(s), visual fields, binocular functioning, accommodative functioning, oculomotor functioning, and/or other pertinent information.

- Actual scores and results from all tests, procedures, measurements, and scales administered to demonstrate the level of impairment to vision functioning must be provided. These assessment data are imperative to allow for a professional review. When relevant to the impairment, examples of such data are: visual acuities (best-corrected for near and distance), visual field print-outs, specific tests of accommodation (e.g., relative accommodation, amplitudes, facility, dynamic or nearpoint retinoscopy), specific tests of vergence (e.g., nearpoint of convergence, cover test, prism vergences, facility), specific tests of reading eye movements (e.g., Developmental Eye Movement test, photo-electric oculogram).

- Detailed information about what therapy, medication, and low-vision aids are being used to treat the impairment, and the effectiveness of these interventions, including all relevant post-therapy data.

- Specific information concerning the current functional limitations imposed by the visual impairment (what the individual can and cannot do on a regular and continuing basis).

- A specific recommendation for all accommodations requested, including low vision aids, and an explanation of how the accommodations will reduce the impact of the identified functional limitations on the testing activity.

- Documentation should be typewritten and submitted on the professional's letterhead and be signed and dated by the evaluator. Handwritten notes, letters, or prescriptions are not sufficient to demonstrate substantial visual impairments.

Visual impairment in one eye only can often significantly impact the ability to perform three-dimensional tasks, such as driving or playing some sports. However, monocular conditions, in and of themselves, have not been shown to cause a substantial limitation in the ability to read or perform other two-dimensional tasks at near. Therefore, requests for accommodations for computer-based tests based on visual impairment in only one eye need to provide data to demonstrate reduced functioning in the fellow eye, such as of accommodation (focusing) or reading eye movements (saccades).
Hearing Impairments

In addition to the General Guidelines for all disabilities, the following information is provided to assist the applicant in documenting a need for accommodation based on a hearing impairment.

The USMLE computer-based examinations (Step 1, Step 2 Clinical Knowledge, and Step 3) each contain a small number of multi-media items which may have an audio component. The Step 2 Clinical Skills (CS) examination involves the use of simulated patients to test medical students and graduates on their ability to gather information from patients, perform physical examinations, and communicate their findings to patients and colleagues. The Step 2 CS examination may involve one or more patient encounters where the examinee is asked to communicate with the patient by telephone.

**USE OF ASSISTIVE DEVICES:** If you are able to access the examination content under standard time conditions and only need to bring/use your assistive listening device(s) (i.e., hearing aids, cochlear implants, amplified stethoscope, etc.) during the examination, a Personal Item Exception (PIE) may meet your needs. The process for obtaining permission to use an electronic assistive listening device during USMLE is brief and requires that you make a written request at least four weeks prior to your anticipated test date. See the USMLE Bulletin of Information [http://www.usmle.org/bulletin/applying-and-scheduling/#disabilities](http://www.usmle.org/bulletin/applying-and-scheduling/#disabilities) for information about Personal Item Exceptions. Contact the PIE Coordinator at 215-590-9700 or pie@nbme.org for additional information and instructions on how to request a Personal Item Exception.

If you have a hearing impairment/hearing loss that is covered under the ADA and that would impair your ability to access the examination content under standard conditions, please follow these Guidelines to request test accommodations.

Comprehensive documentation of hearing impairments must include a report of a clinical evaluation by a qualified professional (otolaryngologist and/or audiologist) and a copy of your most recent audiogram or audiometric report.

The report of evaluation should include:

- Actual scores and results from all tests, procedures, measurements, and scales administered for the evaluation.
- Information about whether the hearing loss is static or changing. Hearing loss of a changing nature may need to be documented more frequently (e.g., within the past 6 months).
- Specific information concerning the current functional limitations imposed by the impairment (i.e., to what extent your day-to-day functioning is impaired by the hearing loss).
- Detailed information about what therapy and auditory aids are being used to treat the impairment, and the effectiveness of these interventions, including any relevant posttherapy data.
• A specific recommendation for all accommodations requested, with an explanation of how the accommodations will reduce the impact of the identified functional limitations on the specific testing activity (this may be different for the CBT examinations vs. Step 2 CS).

Documentation should be typewritten and submitted on the professional's letterhead and be signed and dated by the evaluator. Handwritten notes, letters, or prescriptions are not sufficient.

If you are receiving accommodations at your medical school or have previously received accommodations in other settings, please provide written verification of those accommodations. Note, to verify accommodations in medical school, you should have the appropriate school official complete the USMLE Certification of Prior Test Accommodations form.

Your request must specify whether you require use of hearing aids, cochlear implants, or other assistive listening devices for the day of your examination. Please provide specific information for any assistive listening device, including hearing aids, such as the make and model number, and a photo of the device for our review. Note that the photo should be of your own personal item that you are requesting to bring with you to the examination, not a generic photo of the make/model. At the conclusion of our review, you and your test center will be notified in writing of the item(s) approved for your use during the examination. This approval is necessary as unauthorized possession of personal items while in the secure area of the test center may lead to a finding of irregular behavior and permanent annotation of your USMLE transcript.

Forms

How to Submit a Request for Test Accommodations for USMLE
(for Step 1, Step 2 CK, Step 2 CS and Step 3)
If you have a documented disability covered under the Americans with Disabilities Act (ADA) you must notify the USMLE in writing each time you apply for a Step examination for which you require test accommodations.

New Requests
If you have not previously received test accommodations for USMLE, complete and submit the Request for Test Accommodations to the appropriate address listed on the form. Submit your completed request form and supporting documents at the same time you submit your Step exam application to your registration agency.

Subsequent Request for Test Accommodations
If you received test accommodations for a previous Step exam, complete and submit the Subsequent Request for Test Accommodations to the appropriate address listed on the form. Submit your completed request form at the same time you submit your Step exam application to your registration agency.
Certification of Prior Test Accommodations

If you received test accommodations in medical school/residency submit a completed Certification of Prior Test Accommodations to the appropriate address in the table below, along with your Request for Test Accommodations.

What to Submit

- Legible copies of all documents, not originals
- Typewritten and signed letters and reports from professionals on their letterhead
- Complete reports with all pages, signed and dated
- All documents in English. You are responsible for providing certified English translations of non-English documentation
- Childhood records if your request is based on a developmental disorder such as LD, dyslexia, ADHD
- Documentation beyond self-report of your functional impairment
- Documentation of your functional impairment in activities other than test-taking

What NOT to Submit

- Original documents
- Handwritten or unsigned letters from physicians or evaluators
- Copies of reports with redactions or missing pages
- Multiple copies of documentation (i.e., faxed and mailed copies of a document)
- Duplicate documentation previously submitted to Disability Services
- Previous correspondence from Disability Services
- Research articles, your résumé or curriculum vitae
- Staples, binders, page protectors, folders, or similar items

Contact Information

Test accommodation requests and inquiries should be directed to the appropriate agency listed below:

<table>
<thead>
<tr>
<th>Examination</th>
<th>Type of Applicant</th>
<th>To request test accommodations, contact:</th>
</tr>
</thead>
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| Step 1      | All medical school students and graduates | Disability Services  
National Board of Medical Examiners  
3750 Market Street  
Philadelphia, PA 19104-3190  
Telephone: (215) 590-9700  
Facsimile: (215) 590-9422  
e-mail: disabilityservices@nbme.org |
| Step 2 CK   |                               | Supervisor of Examination Services  
Federation of State Medical Boards  
400 Fuller Wiser Road, Suite 300  
Euless, Texas 76039  
Telephone: (817) 868-4041  
Facsimile: (817) 868-4098  
e-mail: exam@fsmb.org |
| Step 2 CS   |                               | |
| Step 3      | All medical school graduates who have passed Step 1 and Step 2 (CK and CS) | |

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