

**United States Medical Licensing Examination® (USMLE®)
Certification of Prior Test Accommodations (CPTA)**

To be completed and signed by medical school official responsible for student disability services.

Applicant Name: _____ **USMLE ID#:** __ - ____ - ____ - ____

I certify that _____ has officially approved and continuously
Name of School
provided the following accommodations for the above applicant beginning on _____
Date (Month/Year)

1. Accommodation(s) provided for **computer-based, written, or other assessments:**

Reason for accommodation(s): _____

If student is requesting accommodations for **Step 3:**

2. Accommodation(s) provided for **clinical education settings (e.g., ambulatory, inpatient, laboratory-based clinical work):**

Reason for accommodation(s): _____

Name of School Official: _____ Title: _____

Print Name of Official

Title of Official

Signature of Official: _____ Date: _____

Telephone Number: (____) _____

E-mail or fax completed form to:

Disability Services

NBME

Telephone: (215) 590-9700

Fax: (215) 590-9422

E-mail: disabilityservices@nbme.org

Please Note: This form is not a Request for Test Accommodations. Go to <https://www.usmle.org/step-exams/test-accommodations> for detailed information and instructions on submitting a request for accommodations.