ECFMG Clinical Skills Assessment

Administered to Graduates of Foreign Medical Schools by the
Educational Commission for Foreign Medical Graduates (ECFMG®), 3624 Market Street, Philadelphia, PA 19104 USA
Telephone: (215) 386-5900

Questionnaire for CSA® Applicants Requesting Test Accommodations

This questionnaire must be received no later than the application for CSA itself. **Requests must be supported by documentation certifying the disability from a qualified professional appropriate for evaluating the disability. Review of a request for test accommodations will be deferred until the necessary documentation is submitted.** Mail your completed questionnaire and documentation to: ECFMG/CSA Test Accommodations Committee, 3624 Market Street, Philadelphia, PA 19104 USA.

Please type or print.

1. Name: ______________________________

2. Address: ______________________________

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3. Telephone: ______________________________

4. Social Security #: ______________________________

5. Date of Birth: ______________________________

6. USMLE™/ECFMG ID # ______________________________

7. Medical School: ______________________________

8. Nature of Disability:

☐ Hearing Disability ☐ Physical Disability

☐ Visual Disability ☐ Learning Disability

☐ Psychiatric Disability ☐ Other: ______________________________

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9. 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.

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

☐ Less than 1 year ☐ 2 - 4 years

☐ 1- 2 years ☐ 5 or more years

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

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12. Do you require wheelchair access at the examination facility?

☐ Yes ☐ No

13. Prior classroom or test accommodations you have received:

Standardized Examinations

☐ Medical College Admission Test (MCAT) Month/Year ________________

Accommodation Received ____

☐ USMLE™ Step 1 and/or Step 2 Month/Year ________________

Accommodation Received ____

☐ Other ______________________________ Month/Year ________________

Accommodation Received ____

Medical School

☐ Yes ☐ No Date Approved _______________

Accommodation Received ____

If yes, have an appropriate official at your medical school complete the *Certification of Documentation for Test Accommodations*.

College

☐ Yes ☐ No

Accommodation Received ____

Secondary or elementary school

☐ Yes ☐ No

Accommodation Received ____

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14. Certification/Authorization:

I certify that the above information is true and accurate. If test accommodations granted to me include a deviation from the standard testing time schedule, I agree that, from the time I begin the examination until I have completed it, I will not communicate in any way, to the extent possible, with any other individuals taking the examination, and I will not communicate in any way with any individuals about the content of the examination.

Signature ________________________________ **Date** ________________________________

If clarification or further information regarding the documentation provided is needed, I authorize ECFMG to contact the professional(s) and entities to communicate with ECFMG in this regard to provide ECFMG with such clarification and/or further information.

Signature ________________________________ **Date** ________________________________

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