

***Certification of Documentation
for Test Accommodations***

To be completed by an official responsible for student disability services.
Please type or print.

Applicant Name: _____

USMLE® /ECFMG® ID#: _____

Examination: _____

Date: _____

1. I, _____, hold the position of _____.

Name Title

2. I certify that _____ officially approved and
Name of Institution
provided the following test accommodation for the above beginning on
_____.

Date

Accommodation(s) provided:

Reason for provision of accommodation(s):

Signature _____ Date _____

Telephone Number _____

Please mail this completed form to:

ECFMG/CSA® Test Accommodations Committee
3624 Market Street
Philadelphia, PA 19104 USA