EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, U.S.A.
TELEPHONE: 215-386-5900 ● FAX: 215-386-3185 ● INTERNET: www.ecfmg.org

REQUEST FOR RECHECK OF USMLE™ STEP 1 OR STEP 2 CK SCORE

Standard procedures ensure that the score reported to you is an accurate reflection of the responses recorded by the computer on the test date. A change in score as a result of a recheck is extremely unlikely. The recheck report confirms that the score is accurate as originally reported or gives the corrected score. (The score recheck fee will be refunded if the score is changed as a result of the recheck.)

Instructions:

- To obtain a score recheck, complete and sign this request form.
- To submit payment, complete all information requested on the *Payment for Service(s) Requested* (Form 900), which is included with this request form. **Include a payment of US $55.00 for each recheck requested.**
- You should check "Score Recheck: USMLE Step 1/Step 2 CK" in item 2 of the payment form. Submit the completed payment form with your request for recheck.
- Return the completed Form 265 along with payment (Form 900) by fax, to 215-386-3185, or mail to the address listed above.

Important Notes:

- Your recheck request must be received at ECFMG® **no later than ninety days** after your score report release date.
- For more information on score rechecks, please refer to the USMLE *Bulletin of Information*.
- Please allow four to six weeks for your request to be processed.

1

Enter your Identification Number.

USMLE / ECFMG Identification Number: ☐ – ☐☐☐ – ☐☐☐ – ☐

Enter Your Name.

First Name _____ Middle Name _____

Last Name (Surname/Family Name) _____

2
Indicate the exam/date to be rechecked.

Step 1
Date of Examination_____/_____/_____
Month Day Year

Step 2 CK
Date of Examination_____/_____/_____
Month Day Year

3
Address

Send score recheck results to:

_____
Street Address/Post Office Box

_____
Address Continued

_____ _____
City State/Province

_____ _____
Zip/Postal Code Country

4
Signature

Submitted by: _____ _____
Signature Date

EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

BY MAIL: ECFMG, PO Box 48087, Newark, NJ 07101-4887 USA
BY COURIER: ECFMG, c/o Image Remit, 205 North Center Drive, Commerce Center, North Brunswick, NJ 08902 USA
TELEPHONE: 215-386-5900 • **FAX:** 215-386-3185 • **INTERNET:** www.ecfmg.org

PAYMENT

PAYMENT FOR SERVICE(S) REQUESTED

1

Enter your Identification Number.

Enter your name.

USMLE® / ECFMG® Identification Number: ☐–☐☐☐–☐☐☐–☐

First Name(s):

Middle Name(s):

Last Name (Surname or Family Name):

2

Indicate the service(s) for which you are providing payment.

- ☐ TOEFL® Acceptance ($40)
- ☐ Extension of USMLE Step 1 / Step 2 CK Eligibility Period ($50 per exam)
- ☐ ERAS® Token ($75) — ERAS Applicants: Do NOT use this form to pay for transmission of your USMLE transcript via ERAS. Instead, logon to www.myeras.aamc.org.
- ☐ USMLE Transcript ($50 per request form - up to ten transcripts)
- ☐ CVS – State Board ($25)
- ☐ EVSP (J-1 VISA) ($200)
- ☐ Score Recheck: USMLE Step 1/Step 2 CK ($55 per exam)
- ☐ Score Recheck: CSA® ($35)
- ☐ Duplicate Certificate ($25)
- ☐ Name Change on ECFMG Certificate ($25)
- ☐ File Copy Fee ($25)
- ☐ ECFMG Exam Chart ($50 per request form – up to three copies)
- ☐ Previous Balance/Other (Specify): $_____

3

Select a method of payment and complete all information requested.

Do **NOT** send cash.

(A) ☐ **Charge my credit card.**

Credit Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ **Exp. Date (Month/Year):** ☐☐/☐☐☐☐

Check One: ☐ **VISA** ☐ **MASTERCARD** ☐ **DISCOVER**

Name of Card Holder: _____

Address of Card Holder: _____

City: _____

State: _____

Country: _____

Zip/Postal Code:

By signing below, I authorize ECFMG to charge my credit card in the amount indicated above.

Signature of Card Holder: _____

(B) ☐ **My check, bank draft, or money order made payable to ECFMG is enclosed.**

Payment must be made in U.S. funds through a U.S. bank.
Include your USMLE/ECFMG Identification Number on your check.

(C) ☐ **I have sent a wire transfer to ECFMG.**

Funds may be wire transferred through most banks in the United States (Fedwire) to the ECFMG ACCOUNT NUMBER 361024284 at COMMERCE BANK, ROUTING / TRANSIT NUMBER 036001808. Your payment must be identified with your full name and USMLE / ECFMG Identification Number.
Additionally, you must provide the following information:

Date Sent: _____

Originating Bank: _____

Bank Reference Number: _____

Name of Sender: _____

ECFMG Payment Policy

If you owe money to ECFMG at the time that your request is processed, ECFMG will apply the payment included with your request to the amount that you owe. Any money that is left after this will be used to pay for the service(s) that you request. If there is not enough money remaining to pay for the service(s) you request, your request will not be processed.

If you have money in your ECFMG account at the time that your request is processed, it will be used to pay for the next request for service processed by ECFMG. If you have money in your ECFMG account and will not request additional exams / services, you may send a written request to ECFMG for a refund.

Refer to "Payment" in the ECFMG *Information Booklet* for detailed information on ECFMG's Payment Policy.