Federation of State Medical Boards (FSMB)
Attn: Assessment Services
400 Fuller Wiser Rd., Suite 300, Euless, TX 76039-3856
Telephone (817) 868-4041

(Complete top section only)

USMLE STEP 3
CERTIFICATION OF POST-GRADUATE TRAINING FORM

*This section is to be completed by the **applicant** and forwarded directly to the Program Director. It facilitates processing when the PGT form accompanies the Step 3 application. PGT form(s) dated more than 45 days before receipt of the application are not considered current and will not be accepted. (Do not alter this document, if altered this document will not be accepted)*

(PLEASE PRINT)

USMLE ID # enter #!!! Step 3 State Board COLORADO Date of Birth enter

Physician Name ______________________ SS#(optional) ______________
(PLEASE PRINT- Last Name, First Name, Middle Name)

Hospital Name University of Colorado Denver - School of Medicine
(complete name of hospital or university – do not abbreviate)

Address 12631 East 17th Avenue, B177
(complete address of hospital or university)

City Aurora State CO Telephone (303) 724-1784

I hereby authorize the release of all pertinent information, favorable or otherwise, to FSMB.

Signature (Must be original signature. No fax or scanned signatures accepted) Date (Please make sure you date)

This section must be completed by the Program Director, signed, notarized, and forwarded to the FSMB at the above address, by 9/6/2013 for the 2013 USMLE Step 3. Original signatures and notary stamp or notary seal required.

(Please turn forms in to Allison Claybrook to complete)

I certify that the physician named above is serving / has served (CIRCLE ONE) ______ months / years (CIRCLE ONE) in their ______ (PGY-Year)

of post-graduate training at the hospital or university named above. Accredited by one of the following associations:
(please check one)

- ☐ ACGME - Accreditation Council for Graduate Medical Education
- ☐ RCP - Royal College of Physicians
- ☐ RCPSC - Royal College of Physicians and Surgeons of Canada
- ☐ Other - ______________________
- ☐ AOA - American Osteopathic Association
- ☐ CMA - Canadian Medical Association
- ☐ CFPC - College of Family Physicians of Canada

Date post-graduate training began / will begin (CIRCLE ONE): ______ / ______ / ______ (MONTH / DAY / YEAR)

Date post-graduate training was / will be completed (CIRCLE ONE): ______ / ______ / ______ (MONTH / DAY / YEAR)

Please evaluate applicant's competence and conduct during the program: (Use additional paper as necessary.)
Have there been any unusual circumstances during this applicant's participation in the program? Please answer questions below, if YES, please explain: (Use additional paper as necessary.)

Did the applicant ever take a leave(s) of absence or break(s) from your program?	Yes	No
Was applicant ever placed on probation?	Yes	No
Was applicant ever disciplined or placed under investigation?	Yes	No
Were there any negative reports filed against applicant?	Yes	No
Were there any limitations or special requirements imposed on applicant, i.e., academic, incompetence, disciplinary problems or for any other reason?	Yes	No

x______________________ Signature of Program Director

______________________ **PRINT**- Full Name of Program Director

Notary Stamp or Notary Seal Here

Director's Phone #: ______________ Director's Email: ______________________

Sworn to and subscribed before me on this the ______ (Day) day of ______________ (Month), ______ (Year).

x (Allison Claybrook is a Notary)
Signature of Notary Public

______________________ Date Commission Expires

All items must be completed in their entirety. Any form not completed appropriately will not be accepted. No alterations of this form will be accepted.

UNITED STATES MEDICAL LICENSING EXAMINATION®

2013/2014 STEP 3 APPLICATION

CERTIFICATION OF IDENTITY

This form must be signed by a notary public/commissioner of oaths. When completed and submitted to the Federation, this form becomes part of your USMLE record and will be used to identify you when you interact with the Federation if you need to re-apply for the Step 3.

This Certification of Identity is valid for this and any subsequent Step 3 applications submitted to the Federation within a period of five years from the date of the applicant's signature. If you do not sit for this administration of Step 3 or must retake Step 3, it is not necessary to submit another Certification of Identity as long as this form is on file with the Federation of State Medical Boards and has not expired.

To ensure your form is sent out in a timely manner please follow photo measurements and instructions! We will NOT attach photos for you.

ATTACH PHOTO HERE

Securely tape or glue in this square a current front view 2" x 2" color or passport quality photo.

(Print your full name on back of photo before attaching)

USMLE ID: ________________

Type or print in uppercase letters.

Name:

Last First Middle

SSN: ________________ Date of Birth: ________________
(Month/Day/Year)

Gender: ________________

State Licensing Authority for which Step 3 is being taken:

I certify that I am the individual named above, represented in the attached photograph and that the signature below is my signature. I certify that I meet the eligibility requirements for Step 3 and that the information on this form is true and accurate. I also certify that I have read the most current version of the USMLE Bulletin of Information and all relevant instructions for this or any subsequent Step 3 application, that I am familiar with the contents of the Bulletin and agree to abide by the policies and procedures described therein. I authorize the release of my USMLE history to the medical licensing authority for which I am taking Step 3 and agree that my subsequent Step 3 score may also be released to the medical licensing authority.

Applicant Signature ____

(Allison Claybrook is a Notary.)

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required.

State of ______________________________ County of ______________________________

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicants signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this (Day)______ , of (Month) ______ ,(Year)______ .

Notary Public Signature ____

Commission Expiration Date* (Month)_____ /(Day)_____ /(Year)_____

**** The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided.***

Notary Stamp Here

Leave form with Alli to document and send.

Please complete and mail this photo/ID page to:

Federation of State Medical Boards
Attn: Assessment Services
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039-3856