

MEDICAL SCHOOL STUDENT/GRADUATE CONSENT FOR RELEASE OF USMLE TRANSCRIPT

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Recipient Information
(To be completed by School Official)

Contact Name	
Title	
Institution Name	
Mailing Address: Line 1	
Mailing Address: Line 2	
City	State/Province
ZIP/Postal Code	Country
Country/Area Code and Telephone Number	Country/Area Code and Fax Number
E-mail Address	

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Authorization
(To be completed by the Student or Graduate for whom the USMLE Transcript is being requested)

I hereby authorize and request the Educational Commission for Foreign Medical Graduates to release my official United States Medical Licensing Examination (USMLE) transcript to the individual at the institution listed above.

Signature of Student
(Using the Latin Alphabet)

Date (Month/Day/Year)

Name of Student
(Please Print)

USMLE/ECFMG ID # - - -

Date of Birth
(Month/Day/Year) / /

This form is available on the ECFMG website at www.ecfm.org.



Do NOT submit this form to ECFMG by e-mail. Please submit the completed form using one of the following methods:

- **BY MAIL/COURIER:** ECFMG, 3624 Market Street, 4th Floor, Philadelphia, PA 19104-2685 USA, or
- **FAX:** (215) 386-3185

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Enter your Identification Number.

Enter your name.

USMLE® / ECFMG® Identification Number: - - -

First Name(s)

Middle Name(s)

Last Name(s) (Surname or Family Name)

Generational Suffix (Jr, Sr, II, III, IV)

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

- | | |
|---|--|
| <input type="checkbox"/> Application for ECFMG Certification (\$145) | <input type="checkbox"/> ECFMG Exam Chart (\$50 per request form – up to three copies) |
| <input type="checkbox"/> Application for USMLE Step 1/Step 2 CK (\$965 per exam*) | <input type="checkbox"/> ECFMG CSA History Chart (\$50 per request form – up to 10 copies) |
| <input type="checkbox"/> Application for USMLE Step 2 CS (\$1,600 per exam) | <input type="checkbox"/> CVS – State Board (\$55) |
| <input type="checkbox"/> Extension of USMLE Step 1/Step 2 CK Eligibility Period (\$90 per exam) | <input type="checkbox"/> EVSP (J-1 visa sponsorship) (\$350) |
| <input type="checkbox"/> Testing Region Change: USMLE Step 1/Step 2 CK (\$85 per region change*) | <input type="checkbox"/> Reprint ECFMG Certificate (\$50) |
| <input type="checkbox"/> Score Recheck: USMLE Step 1/Step 2 CK/Step 2 CS (\$80 per exam) | <input type="checkbox"/> Name Change on ECFMG Certificate (\$50) |
| <input type="checkbox"/> ERAS® Token (\$145) – ERAS Applicants: Do NOT use this form to pay for transmission of your USMLE Transcript via ERAS. Instead, log in to AAMC's MyERAS website. | <input type="checkbox"/> File Copy Fee (\$25) |
| <input type="checkbox"/> USMLE Transcript (\$70 per request form – up to 10 transcripts) – This form is for institutional payments (accompanying Form 173) only. Individuals submitting Form 172 should see that form for payment instructions. ERAS Applicants paying for transmission of their USMLE Transcript should log in to AAMC's MyERAS website. | <input type="checkbox"/> Translation Fee – Medical School Transcript (\$250) |

*International test delivery surcharges also may apply and must be included in payment. For the list of fees, see the ECFMG website at www.ecfm.org/fees.

Previous Balance/Other (Specify):

\$ _____

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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 AMERICAN EXPRESS

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.