



# Institutional Request for an Official USMLE® Transcript Form 173

- A USMLE transcript includes a complete results history of all USMLE Steps or Step Components taken and for which results are available, as of the date the transcript is processed. For more information, see Scores & Transcripts on the USMLE website.
- ECFMG does not provide USMLE transcripts to state medical boards or other licensing authorities. For information on ECFMG certification status, contact the Certification Verification Service at ECFMG at (215) 386-5900 or visit [www.ecfm.org/cvs](http://www.ecfm.org/cvs).
- To request a transcript for Step 3, contact the Federation of State Medical Boards (FSMB) at (817) 868-4000 or visit the FSMB website at [www.fsmb.org](http://www.fsmb.org).
- To obtain a USMLE transcript for a student/graduate enrolled at your institution, please complete and sign Sections 1 and 2 of the form below.
- Sections 3 and 4 appear on page 2 of this document. Print or type the institution information requested in the space provided and photocopy page 2 of this document. Distribute one copy of each new document to each student/graduate for whom you are requesting an official transcript.
- To submit payment, complete all information requested on the *Payment for Service(s) Requested* (Form 900), which is included with this request form.
- You should check "USMLE Transcript" in item 2 of the payment form.
- Return the completed Form 173 and consent authorization documents (Form 173-B) for each student/graduate for whom you are requesting a transcript along with payment (Form 900) by fax, to (215) 386-3185, or mail to ECFMG, 3624 Market Street, 4th Floor, Philadelphia, PA 19104-2685 USA. **Include a payment of US\$70.00 for one through 10 transcripts, US\$140.00 for 11-20 transcripts, US\$210.00 for 21-30, US\$280.00 for 31-40, etc.**
- Please allow 10 business days for your request to be processed.
- Direct all inquiries to ECFMG at (215) 386-5900.

<b>1</b>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 10%;"></td> <td style="border-bottom: 1px solid black; width: 90%;"></td> </tr> <tr> <td style="text-align: left; padding-left: 5px;">Contact Name</td> <td></td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="text-align: left; padding-left: 5px;">Title</td> <td></td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="text-align: left; padding-left: 5px;">Institution Name</td> <td></td> </tr> </table>			Contact Name				Title				Institution Name	
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<p>The fee for requesting one through 10 official USMLE transcripts is \$70.00. To submit payment, complete all information requested on the <i>Payment for Service(s) Requested</i> (Form 900). Form 900 is included with this request form. You should check "USMLE Transcript" in item 2 of the payment form.</p> <p>Submit the completed payment form with your <i>Institutional Request for an Official USMLE® Transcript</i>.</p>	For Office Use Only
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This form is available on the ECFMG website at [www.ecfm.org](http://www.ecfm.org).

# MEDICAL SCHOOL STUDENT/GRADUATE CONSENT FOR RELEASE OF USMLE TRANSCRIPT

**3**  
**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	

**4**  
**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)

		/			/				
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This form is available on the ECFMG website at [www.ecfm.org](http://www.ecfm.org).



BY MAIL/COURIER: ECFMG, 3624 Market Street, 4th Floor, Philadelphia, PA 19104-2685 USA  
TELEPHONE: (215) 386-5900 • FAX: (215) 386-3185 • INTERNET: www.ecfm.org

### 1

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)

### 2

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

- |  |  |
|--|--|
| <input type="checkbox"/> Application for ECFMG Certification (\$75)  | <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 (\$895 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 (\$1,550 per exam)  | <input type="checkbox"/> CVS – State Board (\$40)  |
| <input type="checkbox"/> Extension of USMLE Step 1/Step 2 CK Eligibility Period (\$70 per exam)  | <input type="checkbox"/> EVSP (J-1 visa sponsorship) (\$325)                               |
| <input type="checkbox"/> Testing Region Change: USMLE Step 1/Step 2 CK (\$65 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 (\$105) – ERAS Applicants: Do NOT use this form to pay for transmission of your USMLE transcript via ERAS. Instead, login 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) – ERAS Applicants: Do NOT use this form to pay for transmission of your USMLE transcript via ERAS. Instead, login 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](http://www.ecfm.org/fees).
- 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     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.