For all Steps and Step Components, a rigorous process is used to ensure the accuracy of scores, including a double scoring method involving independent scoring systems. Therefore, a change in your score or in your pass/fail outcome based on a recheck is an extremely remote possibility. To date, the score recheck process has not resulted in a score change. However, if you wish to request a score recheck, complete and submit this request form. Your request must be received no later than 90 days after your result was released to you.

For Step 1/2 Clinical Knowledge (CK), when a request for a score recheck is received, the original response record is retrieved and rescored using a system that is outside of the normal processing routine. The rechecked score is then compared with the original score.

For Step 2 CS, the ratings received from the standardized patients and from the physician note raters are retrieved, resummed, and reconverted into final scores to verify the accuracy of the original outcome. Encounters and patient notes are not re-rated, and videos are not reviewed during 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$80.00 for each exam for which a recheck is requested.**
- You should check “Score Recheck: USMLE Step 1/Step 2 CK/Step 2 CS” 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 ECFMG, 3624 Market Street, 4th Floor, Philadelphia, PA 19104-2685 USA.
- Direct questions to ECFMG at (215) 386-5900.

Important Notes:
- Your recheck request must be received at ECFMG® no later than 90 days after your score was released to you.
- For more information on score rechecks, please refer to the USMLE Bulletin of Information and the USMLE website at www.usmle.org.
- Score recheck results will be sent to your address of record.
- Please allow four to six weeks for your request to be processed.

---

**USMLE / ECFMG Identification Number:**

First Name(s) | Middle Name(s) | Last Name(s) (Surname/Family Name) | Generational Suffix (Jr, Sr, II, III, IV)

**Step 1** Date of Examination: Day Month Year

**Step 2 CK** Date of Examination: Day Month Year

**Step 2 CS** Date of Examination: Day Month Year

**Signature**

Submitted by: ____________________________

Signature Date ____________________________
Enter your Identification Number.

Enter your name.

<table>
<thead>
<tr>
<th>Service(s) for which you are providing payment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Application for ECFMG Certification ($135)</td>
</tr>
<tr>
<td>☐ Application for USMLE Step 1/Step 2 CK ($940 per exam*)</td>
</tr>
<tr>
<td>☐ Application for USMLE Step 2 CS ($1,580 per exam)</td>
</tr>
<tr>
<td>☐ Extension of USMLE Step 1/Step 2 CK Eligibility Period ($80 per exam)</td>
</tr>
<tr>
<td>☐ Testing Region Change: USMLE Step 1/Step 2 CK ($75 per region change*)</td>
</tr>
<tr>
<td>☐ Score Recheck: USMLE Step 1/Step 2 CK/Step 2 CS ($80 per exam)</td>
</tr>
<tr>
<td>☐ ERAS® Token ($120) – ERAS Applicants: Do NOT use this form to pay for transmission of your USMLE transcript via ERAS. Instead, login to AAMC’s MyERAS website.</td>
</tr>
<tr>
<td>☐ 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.</td>
</tr>
</tbody>
</table>

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

Previous Balance/Other (Specify): $ ___

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.

For detailed information on ECFMG’s Payment and Refund policies, refer to the ECFMG Information Booklet and to the ECFMG website at www.ecfmg.org.

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