LARA/LMD-050 (02/14)

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services
Health Licensing Division
PO Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

# APPLICATION FOR USMLE STEP 3 EXAMINATION

I am applying for the following:

USMLE Step 3 Examination- Fee: $50.00 71-4301-25

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. DO NOT SEND CASH. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

| First Name: | Middle Name: | Last Name: |
|---|---|---|
| U.S. Social Security #: | Birth Date: | |
| Street Address: | Apt/Bldg #: | |
| City: | State: | Zip Code: |
| Phone Number: | Email Address: | |
| Health Professional Permanent ID/License Number: | | Expiration Date: |

1. Have you previously taken the USMLE Step 3 in Michigan? ○ Yes ○ No

2. Have you previously take the USMLE Step 3 in another state? ○ Yes ○ No
   If yes, please list the state(s) and date of exam.

| State | Date |
|---|---|
| | |
| | |

## ELIGIBILITY

To be eligible to take the USMLE Step 3, you must establish BOTH of the following:
a) That you have passed the USMLE Step 1 and USMLE Step 2 exams and
b) That you have completed not less than six months of postgraduate clinical training in a program approved by the board.

## INSTRUCTIONS TO APPLICANT

It is your responsibility to assure that the following two documents are provided to this office directly from their sources:
1) USMLE Step 1 and USMLE Step 2 examination scores from the Federation of Medical Boards and
2) Certification of completion of at least six months of postgraduate clinical training on the following form from your Program Director.

Signature of Applicant _____ Date _____

Michigan Department of Licensing and Regulatory Affairs
**Board of Medicine**
PO Box 30670
Lansing, MI 49809
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# CERTIFICATION OF POSTGRADUATE TRAINING

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, certification will not be issued.

## SECTION I - APPLICANT INFORMATION

Instructions: Complete Section I. Type or print your name exactly as it appears on your application. Print this form and then for completion of Section II, send this form to the Director of Medical Education where you completed your postgraduate training. This certification must be submitted directly to the Michigan Board of Medicine by the Director of Medical Education.

## SECTION I - APPLICANT INFORMATION

| | | |
|---|---|---|
| First Name: | Middle Name: | Last Name: |
| Street Address: | | Apt/Bldg#: |
| City: | State: | Zip Code: |
| SSN: | Date of Birth: | |
| Email: | Phone Number: | |
| All Previous Names and/or Birth Name Used (if applicable): | | |

Signature _____ Date _____

Upon completion of Section I, print, sign, and date the form then send the form to the Director of Medical Education for completion of Section II.
**This certification must be submitted directly to the Michigan Board of Medicine .**

Full Name:

## THIS SIDE TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

### SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

Please complete the following information. Return this completed certification directly to LARA, Michigan Board of Medicine, PO BOX 30670, Lansing, MI, 48909.

| Name of Hospital | | |
|---|---|---|
| Street Address of Hospital | | |
| City | State | Zip Code |

I certify that _____ a graduate of
(Applicant's Full Name)

the _____medical school, has successfully completed postgraduate clinical training offered by the

hospital named above from _____ to _____,
(Month/Day/Year) (Month/Day/Year)

in the clinical area of _____.

Is this an active training program accredited by the ACGME, the College of Family Physicians of Canada, The Royal College of Physicians and Surgeons of Canada, or by the National Joint Committee on Accreditation of Preregistration Physician Training Programs of the Canadian Medical Association? ❒ Yes ❒ No

_____ _____
Signature of Director of Medical Education Date of Signature

_____ (Seal)
Print or Type Name of Director of Medical Education If hospital has no seal, please indicate

**NOTE:** Certification of Postgraduate Training will not be accepted if signed and submitted more than 15 days prior to actual completion.