INTERNATIONAL FOUNDATIONS OF MEDICINE® (IFOM®)

How to Request a Score Recheck for IFOM BSE and CSE

If you have recently taken an IFOM examination, you may request a score recheck by completing the "Score Recheck Request Form For IFOM BSE and CSE". There is a $35 service fee for each score recheck. **Payment must accompany the request. Your request must be received by the NBME no more than 4 months after your test date.**

For all IFOM Examinations, standard procedures ensure that the scores reported for you accurately reflect your performance. A change in score based on a recheck is an extremely remote possibility. However, a recheck will be done if you submit the request form and fee to the NBME.

INSTRUCTIONS FOR COMPLETING THE SCORE RECHECK FORM

(Use blue or black ink to complete this form)

1. **EXAM TO RE RECHECKED:** Check the appropriate box(es) to indicate which exam(s) you would like rechecked (IFOM BSE or IFOM CSE). Enter the date of your exam(s).
2. **ID#:** This is the ID number entered on your score report.
3. **FEE ENCLOSED:** The fee is $35 for **each** score rechecked. Please include a money order with your form, made payable to the "NBME" in US currency.
4. **NAME:** Enter your name as it appears on your score report.
5. **CONTACT INFORMATION:** Enter your current mailing address, telephone number, and email address.
6. **MEDICAL SCHOOL:** Enter your medical school's name, city and country.
7. **SIGNATURE/DATE:** Sign your name and enter today's date.
8. **MAILING INSTRUCTIONS:** Mail your completed form and fee via first-class mail or overnight delivery to:

   National Board of Medical Examiners
   Attn: IFOM Test Administration
   3750 Market Street
   Philadelphia, PA 19104-3190

   We strongly recommend that Score Recheck Forms be sent by a traceable courier service.

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Score Recheck Request Form for IFOM BSE or CSE

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EXAM TO BE RECHECKED:	☐ **IFOM BSE** Exam Date: ____/____/_____ ☐ **IFOM CSE** Exam Date: ____/____/_____
ID#:	
FEE ENCLOSED:	$ ☐☐☐.☐☐ US Dollars ($35.00 for each score to be rechecked, made payable to NBME)
NAME:	Last Name: First Name: Middle Name:
CONTACT INFORMATION:	Street Address/Apartment #: Street Address: City, Zip Code: Country: Phone Number: Email Address:
MEDICAL SCHOOL:	School Name: City/Country:
SIGNATURE/ DATE:	Signature: Date:

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