



**Examination Application**

Examination Fee: \$750.00

INSTRUCTIONS

- 1) All COMVEX candidates MUST obtain approval from a state medical board prior to submit the application.
- 2) Candidate MUST complete the application form and return it to the NBOME with the examination fee.
- 3) Candidate will be notified by the NBOME to schedule an appointment.
- 4) Please allow for up to ten (10) business days for application processing before contacting the NBOME office.

**Please type or print all information on the application and submit to Client Services at the NBOME Corporate Offices and Conference Center at 8765 West Higgins Road, Suite 200, Chicago, IL 60631-4174.**

Please check one: \_\_\_ Initial COMVEX examination      \_\_\_ Retake COMVEX examination

NBOME ID (*if known*): \_\_\_\_\_

Name: \_\_\_\_\_  
*(As on photo ID)* Last First Middle

Date of Birth: \_\_\_\_\_  
Month/Day/Year

Medical School: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street

\_\_\_\_\_ City State/Zip Code

Email Address: \_\_\_\_\_

Day Phone No: (\_\_\_\_) \_\_\_\_\_ Evening Phone No: (\_\_\_\_) \_\_\_\_\_

***I hereby agree to the general condition set forth in the Bulletin of Information for COMVEX, and the policies and procedures related to the COMVEX examination, specifically those concerning test administration, payment of fees, and reporting of scores. I agree to maintain in strict confidence the examination items included in the COMVEX examination. I certify that I am the person who will take the test at the center and whose name and address appear on the application.***

Candidate Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Licensing Authority Requesting COMVEX: \_\_\_\_\_  
*(State Medical Board)*

Contact Person: \_\_\_\_\_ Contact Phone No: \_\_\_\_\_  
*(State Medical Board)*

Signature: \_\_\_\_\_ Email Address: \_\_\_\_\_