Usmle step 1 dates 2021 pakistan

Post Graduation & Specialization in U.S.A. Important Terms & Concepts The first term you should know is IMG, or International Medical Graduate also known as an FMG, or Foreign Medical Graduate. You are an IMG to the relevant American authorities if you have graduated from a medical college outside of the US or Canada. This has no bearing on your nationality. You could be an American and still be an IMG if you have gained your medical degree outside the US or Canada. Indeed, a non-American who has attended medical college inside the US or Canada, will not be considered an IMG. So a Pakistani, Indian, Malaysian, Saudi, Briton and even an American who graduated from a medical college outside the US or Canada is an IMG. Another important term is GME, or Graduate Medical Education. This refers to further medical training in the US after medical school that will, after its completion, allow the trainee to practice medicine independently. This is, in other words, post-graduate medical training, or as we popularly know it in Pakistan, specialization. In America, the specialization, or GME, is pursued by working as a resident in a program. For our purposes, a program can be understood as a hospital that has an active teaching element incorporated into its setup. A resident is the doctor who is working in such a hospital. The period of time of your further training, i.e., your �specialization� is called your residency and it can last from 3 to 7 years depending on which field you�re specializing in. There are many fields, or specialties but practically speaking, there are just a few specialties that IMGs have a realistic chance of securing these days. The most common specialties IMGs are accepted into are Internal Medicine and Family Practice, which together account for about 60% of all the residencies that IMGs are accepted into. Most other specialties are difficult (not impossible) to get into. In Dermatology, for example, only 1% of all residents are IMGs. Basically, the residency is an intensive period of training at the end of which you will be capable of practicing medicine without requiring the supervision of senior doctors. After completion of the residency in your specialty, you may choose to pursue a subspecialty. For example, if your specialty was Internal Medicine, then you could sub-specialize in Cardiology or Gastroenterology to name just two possible subspecialties. Usually, a person who enters a program for a subspecialty is called a fellow, and he is said to be doing his fellowship. The residency is a paid job. You will be working for the hospital and in return they will train you and pay you between 35 to 40 thousand dollars a year. This much money is adequate to live comfortably on and support a family. Therefore, when a person starts his residency, he does not have to worry about finances if he is sensible with his money. When an IMG secures the residency, he is offered a long term contract lasting several years, so his future with that program is secured for at least 3 years, and he does not have to worry about being removed from the residency during this time unless he suddenly becomes grossly incompetent. A short history of how GME in the US evolved is very useful in understanding most of the terms you�ll encounter in your journey. Since the USMLE process is so long, a hopeful candidate who comes across an unfamiliar term or acronym in a newsletter, online forum, application form, bulletin, or the hundreds of websites related to the USMLEs, may start to think that he�s discovered a deficiency in his knowledge that may prevent him from maximizing his potential. The purpose of the proceeding section is to avoid this potential blow to a candidate�s confidence. By viewing the GME process in its historical context, its different components make a lot more sense, and acronyms like NBME, ECFMG, FSMB, FLEX, or FMGEMS will not intimidate you when you know exactly what they are. In the mid 1950s, the healthcare sector in the US started expanding rapidly and gave rise to a large demand for junior doctors. This demand was partly met by foreign doctors who started coming to the US for further training in increasing numbers. They would not only receive further medical training, but also provide invaluable services to the US medical infrastructure. However before foreign doctors were granted the license to practice medicine in the US, the competency of those doctors had to be established. In order to make sure that foreign trained doctors met the minimum standards of competence required to safely practice medicine, a body was formed in 1954 called the Cooperating Committee on Graduates of Foreign Medical Schools (CCGFMS). This body was formed in collaboration with a number of other medical organizations like the AAMC, AHA, AMA, and FSMB. The CCGFMS was told to come up with a system of assessing the overseas doctors in order to distinguish the competent IMGs from the incompetent ones. To this purpose, the CCFGMS put forward three basic requirements which can be summarized as follows: The medical credentials of the foreign doctors must first be verified. The medical knowledge and clinical skills of foreign doctors should be tested. In other words, a test (or tests) had to be devised that all foreign doctors would have to take and pass in order to prove that they had the medical knowledge required to practice medicine. The ability of foreign doctors to communicate properly in English must be tested. These three basic principles, which were proposed 50 years ago are still followed to this day, although the techniques used to enforce them have become increasingly sophisticated over time. Of these three recommendations, the area that underwent the most extensive revision has been the second principle of testing the IMG�s medical knowledge as we shall soon see. How the Working Started ! When the CCGFMS put forth these recommendations, another body was created to enforce them. This body was formed in 1956 and was called the Evaluation Service for Foreign Medical Graduates (ESFMG). By the end of 1956, the name was changed to the Educational Council for Foreign Medical Graduates (ECFMG) - a name you will come across often. The ECFMG went to work, and they soon developed a procedure of validating a foreign doctor�s medical degree, which was the easiest part of the CCGFMS recommendations. In order to implement the second and third recommendations of the CCGFMS, the ECFMG worked together with an organization called the National Board of Medical Examiners (NBME). As the name suggests, the NBME saw to it that the exams administered by American medical colleges to its own students met the high standards demanded of them. As such, the NBME had a lot of experience with medical exams, and its help was sought by the ECFMG. Together these two created a standard set of exams that would be administered to all foreign doctors who wished to pursue GME in America. Along with a set of exams to test for medical proficiency, the ECFMG and NBME also developed an English language proficiency test. If the foreign medical graduates failed any of these exams, they would not be allowed to train further in America. How this ECFMG Testing System Evolved ! In 1958, the ECFMG administered the test for the very first time. Only 298 doctors sat for the exam. The exam was called the American Qualification Exam, or AMQ. An exam for English was also introduced called the ECFMG English Examination. The next year, the name of the medical exam was changed from AMQ to the ECFMG Examination. These exams, both the medical and English ones, kept changing names and formats every few years. There were other exams that ran side-by-side to these exams which were also accepted. These were the Federation Licensing Examination (FLEX), and the NBME Part I and Part II exams. In 1981, the Test Of English as a Foreign Language (TOEFL) began to be accepted as an adequate English language proficiency test. In 1984, the ECFMG medical exam was altered and renamed to Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS). In the following years, a few more changes were made to the exams until in 1992, a new exam format was introduced called the United States Medical Licensing Examination, or USMLE which today, is the only exam administered to foreign doctors wishing to pursue GME in the US. (Note that the FLEX, the FMGEMS, and the NBME Part I and Part II exams are still accepted by the ECFMG as valid. If you have taken them and passed, you will be allowed into the US to practice medicine. However, it has been 10 years since these exams have been discontinued, so the number of candidates having passed the FLEX, NBME Part I or NBME Part II is going down. I only mention this point because it is officially stated ECFMG policy to accept these examinations as proof of competency, so if you come across such a statement anywhere, don�t start looking around for application forms for the NBME, FMGEMS, or FLEX exams. They don�t exist anymore. The policy is only stated for the benefit for those old graduates who might have given these exams long ago, gone outside the US to practice medicine, and wish to return to the US to practice.) The USMLE was created by the NBME and another body called the Federation of State Medical Boards (FSMB), which is a union representing all the different medical boards of the States of America as well as some areas outside the US. In 1992, when the USMLE was first introduced, the exam had three separate parts, consisting of a Step 1, a Step 2 and a Step 3. When the USMLE was being designed, the original blueprint on which basis the exam was being constructed stated that an exam testing clinical skills (not just knowledge) was also necessary. Such an exam had not already been designed at the time so work was initiated to create one that would test the clinical skills of different candidates in a fair, reliable and standardized way. As the USMLE exam was introduced in 1992, the FSMB and NBME started working together to construct a reliable clinical exam. The end result of years of research and designing was the introduction, in 1998, of the CSA, or Clinical Skills Assessment. This exam tested the candidate�s clinical skills by using real-life trained actors called standardized patients or SPs. This became an additional exam that had to be taken along with the Steps 1, 2 and 3. In June 2004, the CSA exam was replaced with the Step 2 Clinical Skills (Step 2 CS) examination. While the content, type of examination, scoring, and length of time of the Step 2 CS and the CSA are identical, one important difference is that in the Step 2 CS exam, the candidate�s communication and comprehension skills in the English language (as he interacted with the standardized patient) was actively tested as a separate component of the examination. If the candidate fell short on the English proficiency requirement built into the Step 2 CS exam, he will fail the exam as a whole. In most other respects, the Step 2 CS and CSA exams are very similar. Naturally, when the CSA exam was redesigned (and renamed to Step 2 CS) there was no longer a need for the TOEFL exam. Resultantly, from June 2004 the TOEFL exam was no longer a requirement. Another change that came with the evolution of the CSA into Step 2 CS is that the exam which was previously simply known as Step 2 now became known as the Step 2 Clinical Knowledge exam, or Step 2 CK. Currently, when a candidate passed both the Step 2 exams, he will have been tested for sound clinical knowledge with the Step 2 CK as well as for sound clinical skills with the Step 2 CS. Note however that while these two exams complement each other in assessing the candidate�s strength in clinical medicine, they are still separate exams. They are applied to separately, with separate fees to be paid, and separate result cards returned. Further, while the Step 2 CK can be taken in Pakistan, the Step 2 CS can only be taken in the US (there are five centers, in five cities, where the exam is administered). This discussion brings us to 2005, where the current set of exams that a candidate must give to enter GME in the US are: USMLE Step 1. USMLE Step 2 CK. USMLE Step 2 CS. USMLE & Residency Application Process The entire process, which includes the exams, the traveling, and visa processing fees will cost about Rs. 600,000 to 700,000. Information on how to study for the USMLE or which books to use is deliberately not included here for the reason that there are no universally agreed upon answers to these questions. Furthermore, as generally agreed upon lists of recommended books keep changing every year, any list included here would only be accurate only for a short while. However, some basic principles contributing to success do apply: Firstly, seek guidance on which books and other study materials to use by direct face-to-face interaction with people who have achieved high scores recently. This is especially true for Step 1 and Step 2 CK. Do not rely on advice from high-scorers who took the exams two or three years ago. Such people would probably tell you themselves that their information is out-dated. Secondly, try to study in libraries (or have regular contact with people in libraries) where there are people who have taken the Steps and others who are studying for the Steps. In the AIMC library for example, candidates who have scored highly are always available to advise on which books to use, which subjects to focus on, which mistakes to avoid, how to time yourself, how to handle stress, etc. Candidates usually return to the library after having done a Step and share their experiences with the people there. As a result libraries like these contain a collective pool of knowledge on the various aspects of the USMLE exams - not just about the right books, but about exam trends as well. In the AIMC library, this attitude of sharing knowledge and experiences about the Steps has, over the last few years, inspired a lot of confidence in the existing knowledge-base on how to score well in the exams. As a result, the number of high-scoring candidates has increased sharply over the last few years. If you can�t study in such a setting, for whatever reason, repeated visits to such libraries and groups will give you an idea how to study for the exams in a way that best suits your capabilities and needs. Consequently, the information on the Step exams below only provides a basic introduction. This is probably considered to be the most difficult of all the Steps. The subjects tested are: Pathology. Pharmacology. Physiology. Anatomy (Gross, Histology, Neuroanatomy, Embryology). Behavioral Sciences and Biostatistics. Biochemistry. Microbiology. Interdisciplinary topics, such as nutrition, genetics and aging, molecular and cell biology. The Step 1 is an 8 hour, computer-based exam in which �Single One Best Answer Questions� are asked. With the question asked, will be a list of 3 to 11 possible answers. Some of the possible answers may be partially correct, but you�ll have to choose the best one out of all the options. Example Question A 32-year-old woman with type 1 diabetes mellitus has had progressive renal failure over the past 2 years. She has not yet started dialysis. Examination shows no abnormalities. Her hemoglobin concentration is 9 g/dL, hematocrit is 28%, and mean corpuscular volume is 94 �m3. A blood smear shows normochromic, normocytic cells. Which of the following is the most likely cause? Acute blood loss. Chronic lymphocytic leukemia. Erythrocyte enzyme deficiency. Erythropoietin deficiency. Immunohemolysis. Microangiopathic hemolysis. Polycythemia vera. Sickle cell disease. Sideroblastic anemia. Thalassemia trait. The correct answer being D. The exam consists of approximately 350 questions which are divided into 7 sixty-minute blocks. Once you start a block, you can attempt the questions within it in any order you wish and can even change the answers, However, once you exit a block to move on to the next one, that block is sealed and you can no longer change the answers in it. Official �break-times� are included within the 8 hours of this exam. In order to maximize your potential you need to make sure you don�t take breaks that are too long, or too early, or too late into the day. To this end, you must be thoroughly familiar with the rules governing these break times and try to simulate the exam at home before actually giving it. Sample CDs are available that contain 40 blocks of questions which you can use to simulate the exam several times over at home by solving 7 blocks in 8 hour periods. This will not only build up stamina, but also help you decide how best to manage your breaks in the exam. For more detailed information, you should go through the Step 1 Content Description and Sample Test Materials manual, which is updated and published annually by the FSMB and NBMS and available online (for free). This manual includes many sample questions, a detailed �syllabus� of the Step 1 content, and general advice on how to approach the exam. USMLE STEP II - CK (Clinical Knowledge) To quote the Step 2 Content Description and Sample Test Materials manual, Step 2 CK includes test items in the following content areas: Internal medicine, Obstetrics and gynecology, Pediatrics, Preventive medicine, Psychiatry, Surgery, Other areas relevant to provision of care under supervision. Most Step 2 CK test items describe clinical situations and require that you provide one or more of the following: A diagnosis, A prognosis, An indication of underlying mechanisms of disease, The next step in medical care, including preventive measures. The Step 2 CK is an 9 hour, computer-based exam in which �Single One Best Answer Questions� are asked. Like the Step 1, with the questions asked, will be a list of possible answers. Some of the possible answers may be partially correct, but you�ll have to choose the best one out of all the options. Step 2 CK contains approximately 370 questions which are divided into 8 sixty-minute blocks. The same principles regarding working within a block and time-breaks apply to the Step 2 CK just as they do to the Step 1. As with the Step 1, a Step 2 Content Description and Sample Test Materials manual is published annually by the FSMB and NBMS and contains detailed information about the content of this exam. USMLE STEP II - CS (Clinical Skills) This exam can only be given in the US, unlike the Step 1 and Step 2 CK exams which are administered in Pakistan. To quote the official USMLE website regarding Step 2 CS: It is a one-day test that mirrors a physician's typical workday in a clinic. For 15 minutes each, examinees will examine 12 �standardized patients," people trained to act like real patients. Examinees are expected to establish rapport with the standardized patients, elicit pertinent historical information from them, perform focused physical examinations, communicate effectively, and document findings and diagnostic impressions. After each encounter, examinees have 10 minutes to record a patient note, including pertinent history and physical examination findings, diagnostic impressions, and plans for further evaluation if necessary. The cases will cover common and important situations that a physician is likely to encounter in a general ambulatory clinic. Standardized patients are selected to represent a broad range of age, racial and ethnic backgrounds. Other possible stations include third party interviews (e.g., caregivers for children or frail elderly patients), telephone encounters, and physical examination stations. Pelvic, rectal, and female breast exams will not be part of the initial administration, but may be added later using mechanical simulators. When the first version of this exam, the CSA, was first introduced in 1998 as an essential requirement for an ECFMG certification, the number of IMGs entering residencies in the following Match dropped significantly. This was because at the time, this Clinical exam was new and IMGs didn�t know how best to approach patients in an American healthcare system. Since then however, many books regarding the CSA/Step 2 CS exam have come out and currently, the exam is not seen to be particularly difficult after a month or two of preparation. Unlike the Step 1 and Step 2 CK exams, the result of the Step 2 CS is either a pass or fail with no numerical score. Step 3 is a 16 hour exam taken over two days in 8 hour testing periods. Step 3 is not required to get the ECFMG Certification. Many American medical graduates take the Step 3 by the end of their first year of residency. The reason most IMGs take the exam before their residency starts is because a pass in Step 3 is required to apply for an H1-B VISA. If you don�t want such a visa, you don�t need to take it before your residency begins (visa issues are explained below and the correlation between Step 3 and the H1-B visa will make more sense then). The Step 3 tests your ability to practice medicine in an unsupervised setting. In particular it tests your ability to: Treat patients who come to you for the first time for treatment. Administer continued care (there is greater emphasis on this stage of patient care). Manage patients in an emergency setting. Sequence of USMLE Examinations You can give the Step 2 CK and Step 1 in any sequence you wish. However, it is strongly recommended that you take Step 1 before Step 2 CK. The Step 1 tests knowledge in applied clinical sciences which lays the foundation for the subjects tested in Step 2 CK. Therefore, it is logical to do Step 1 before Step 2 CK. Recently a change in the eligibility for Step 2 CS has been introduced. Previously, it was necessary to have passed at least Step 1 in order to be eligible for Step 2 CS. This prerequisite has now been removed and a candidate can appear for the Step 2 CS as his very first USMLE exam. The only limitation imposed on eligibility is that the candidate must have finished the basic medical sciences (i.e., Anatomy, Physiology, Biochemistry, Pathology, Pharmacology and Community Medicine) in his medical college/university. Therefore, this exam can now be given while you are still a medical student. This change has significant implications for the visa issues - which will be explained later. The Step 3 is the last examination that you will take. You need to have passed the Step 1 and both Step 2 CK and CS before you are allowed to sit for this exam. Over the years, the process of getting a residency has become complicated. Books have been written explaining the process. There are many steps involved, and a detailed discussion of them is beyond the scope of this manual. For our purposes, a very brief step-by-step sequence will be sufficient. By passing the Step 1, Step 2 CK and Step 2 CS, you�ll apply for and receive your ECFMG Certification. This certificate attests to the fact that you have the required clinical knowledge and skills as well as the language skills to train in a residency program in the US. You need this certification in order to work as a resident. You can however begin the job application process before having attained your ECFMG � in that you can start the application process on the strength of your Step I and Step 2 CK passes, as it will be assumed that you will be giving the Step 2 CS in the near future. ERAS - Electronic Residency Application Service When applying to a residency position, the first step is to send all the required documents to a service called ERAS, the Electronic Residency Application Service. The ERAS is a service that provides a standardized, cost-effective means of forwarding applications from the candidate to the different programs he is applying to. It is mandatory for all applicants to apply via ERAS. This is how it works: Some documents (your CV and Personal Statement) are sent to ERAS by uploading them directly to the ERAS website. Other documents (your photographs, examination transcripts, letters of reference, and dean's letter) are sent to the ERAS headquarters in Philadelphia by post or courier service. When these posted documents are received, they will be digitally scanned and attached electronically to your application. Consequently, your entire application for a residency position will be in an electronic format. You will then indicate to ERAS which programs you wish to apply to, and ERAS will then email your entire application to them. ERAS provides this service at cost that increases in proportion to the number of programs that an applicant applies to. On the 1st of September of every year, ERAS begins to send the applications (that have been approved by the candidates as being ready to send) to the residency programs. It will continue to send applications till November of the same year. Therefore, all applications by candidates must be completed and given over to ERAS within this window period between September to November. It is strongly recommended that your application is complete and sent to the programs as soon as ERAS starts sending them, i.e. 1st of September. The reason is that programs tend to decide on who to short-list for the interviews (see below) quickly - so the sooner your application reaches them, the better the chances are that you�ll be amongst those short-listed for an interview. Around November, the program directors (those in charge of the program) short-list candidates they feel are promising and call them for face-to-face interviews. This means you�ll have to go to the US. The interview �season� starts from November and continues till January. The programs that short-list you for interviews will inform you of the fact, and you will then schedule the interview somewhere in the interview season at a date which is convenient to you. It is recommended that you schedule the interviews early in the interview season. If you schedule the interviews late, there is a chance that the program has already decided to hire applicants (who have come to the interviews before you) into all the available resident slots. The sooner you meet the program directors, the better your chances are that you�ll be offered a position. It is a good idea to schedule interviews with programs you are most interested in somewhere in the middle of your schedule. This way, by the time you are interviewed by those programs, you�ll be oriented to the process, but at the same time not exhausted by it. Many people go to the US not just to give their interviews, but also to give Step 2 CS and Step 3. However, it would be best if these exams are taken, and the results included in the ERAS application before the interview season starts. Attaining the ECFMG Certification (by passing Step 1, Step 2 CK and Step 2 CS) by the time you are first applying will naturally strengthen your application. For that matter, a Step 3 pass by the time of the interview season would also strengthen your application, especially if you are seeking a �Pre-match� (see below) for an H1-B visa. Around the time you send your ERAS applications (i.e., early September) you will also register online to participate in the National Resident Matching Program (NRMP), also called �The Match�. The NRMP gathers what is called a �rank order list� from both the candidates and the residency programs. A rank order list submitted by the candidate lists the programs he would like to join his in order of preference. At the same time, the programs also send the NRMP a list of candidates they would like to hire in their order of preference. Naturally, this list will be submitted after the interviews have taken place, when both parties have met, assessed, and �ranked� each other. The rank order lists (submitted by all the candidates and all the programs) are gathered before a fixed deadline. Then, on a fateful day in March, a computer algorithm processes the rank order lists and programs are matched with their candidates. A candidate will be matched with one program (no more). For the program, the match result is binding in that it cannot ignore the match result and decide not to hire you. Sometimes a residency program may like a candidate enough to offer a position well before the match (sometimes as early as November or December). Community-based hospitals (i.e., those hospital not affiliated with a medical school) are more likely to make such offers, but some University programs may do so as well. In general, unless a candidate is very certain that he or she is a very strong candidate and stands a very good chance of matching in a very good university program, the pre-match is a very good opportunity to ensure a job rather than taking the risk of not getting matched. The down side is that you may have to content yourself with a hospital that may not be your first choice. Even then it has the great advantage of giving you a larger time interval (up to 6 months) to apply for your visa, increasing the likelihood that you�ll be able to have your visa approved in time. Most of the Pakistani residents currently in the US would strongly recommend accepting a prematch offer given the uncertainty of the visa situation these days. An important point here is that if you do intend to accept a prematch, make sure that you mention in your interview that you are open to prematch offers. Unless you ask for it, they have no way of knowing. Having all your exam results in hand (Steps 1, 2 and 3) increases the likelihood of residency programs offering a prematch. A few days after the match result is out (and you have been successfully matched), the hospital you have been matched with will send you a letter of appointment. The appointment letters from the hospitals are mailed on the third Thursday of March - the day after the Match officially closes. Upon getting the letter, you will then apply for a visa (from your home country) to work in the US. The problems associated with visas will be discussed in detail later on. If visa problems don�t interfere, you�ll be able to reach the US in June, and settle down to start working in your program from the 1st of July. Several factors influence your chances of securing a good residency. When IMGs reach the stage at which they�re applying for a residency, they all have ECFMG Certification (or are close to getting one), so candidates who apply to programs are selected on the basis of other criteria. You can be a weak candidate, or a strong one and this will influence your chances of securing a good residency. The following factors improve chances of getting a good residency. High Step 1 and Step 2 CK scores (not an easy task). Research experience. (An original research article in an international medical journal will be a very, very strong asset). Elective experience in the US. An elective is a brief clinical or research experience with a program in the US. It is taken only by medical students, not graduates. A clinical elective helps a lot more because it proves you have worked within, and have become familiar with, the American health care system � an strong asset for an IMG. Strong letters of recommendations from American doctors who supervised you during your elective experience. A strong extra-curricular record. Programs prefer to have well-rounded candidates who are also personally well developed alongside their professional qualifications. Step 2 CS and Step 3 passes at the time of applying. Impressing the people at the program (during your interview) as being a likeable, intelligent, and over-all decent human being with strong grasp of the English language. Last but not least, in America (as is true everywhere) it�s not just how much you know but also who you know. If you know someone in a residency program or a practicing physician who knows people in a residency program, that just might be your biggest asset. At times it is more useful than USMLE scores or letters of reference. Such a person could intervene on your behalf and convince the program directors that you�d make a great resident and that they should definitely hire you. At the other end of the spectrum are factors that will actively hurt an IMGs chances of getting a position in a program: Low Step I and Step II scores. Zero extra-curricular activities. Personally not likeable and very poor English, both of which will come across during the interview. Basically, the people who hire a resident are looking for a person who is not only a competent doctor, but who will also make a pleasant co-worker. If the candidate comes across positively on both of these counts, his chances of getting a residency will improve, and vice versa. Example of a Time-line for Planning USMLE It is important to make sure that you give the Steps in an order that maximizes the chances of securing a residency in the US. This requires careful planning and the discipline to follow the plan through. Keep in mind that the time-line proposed below is considered to be optimum in the sense that it maximizes the chances of securing a good residency, but this should not be taken to mean that deviating from this time-line will make it impossible to succeed. To establish a reference point, the time-line below starts from January 2006. Assuming that you graduate or finish your house job in January 2006 (the usual date for students of Khyber Medical College), you should take the Step 1 after 7-8 months of studying in August 2006. It will be difficult to begin studying immediately after your Step 1 because you�ll be tired and more importantly, distracted by the wait for the Step 1 result. Lets assume you restart your studies in mid-September, by which time you should have received your Step 1 result. For the Step 2 CK, 3-5 months of study is considered adequate, which brings us to March 2007, at the latest for the Step 2 CK date. Let�s assume for now that the Step 2 CS is the third exam you�ll give (remember, it is now possible to give it as the first exam, even while you�re still a student). Lets suppose there are no visa problems and you are able to go to the US and take the Step 2 CS in May 2007 with the month of April spent studying for the Step 2 CS. A month or two of preparation for the Step 3 should be enough so that you�ll be able to give this exam in July, or August 2007 at the latest. With all the Steps done by August you�ll sit down, consult with seniors, make enquiries, and think long and hard on making a very careful and realistic list of programs you feel you have a good chance of getting into. With this list in hand, and all your documents sent to ERAS by the time it opens on the 1st of September, you�ll have a complete application to send to the programs. Logical Answer to this Proposed Timeline The basic aim of the time-line above is to have as have passed as many Steps of the USMLE exams before ERAS opens in September. It is worth stressing that at the very least, the Step 1 and Step 2 CK exams must have been completed by July of the year you are applying. As explained previously, having very good Step 1 and Step 2 CK passes at the time of applying will make the residencies more likely to short-list you for interviews. Applying with only a Step 1 pass, even if the score is excellent, is taking a risk. Furthermore, with only a Step 1 pass at the time of applying, you�ll be very pressed for time because in the 6 months following July, you�ll not only have to prepare your ERAS documents, but also study for the Step 2 CK, make travel arrangements to the US, research and choose your programs, travel to interviews in the US, and on top of all that find that time to take the Step 2 CK, Step 2 CS and the Step 3. It won�t make a lot of difference if you don�t have Step 2 CS and Step 3 passes by the time ERAS opens. In other words, not having the Step 2 CS and Step 3 results by the time of applying will not actively hurt your chances of getting interview calls, but on the other hand, having them will actively help your chances. As the Step 2 CS and Step 3 are usually always passed by candidates who have very good Step 1 and Step 2 CK scores, residencies assume that for such candidates, an ECFMG certification is only a matter of time. This is why it is entirely feasible to apply with just Step 1 and Step 2 CK passes and still expect to get good interview calls. Basically, a visa is a permit allowing you to enter another country, and in this discussion, this country in question, is the United States. If you are a non-US citizen, then you will need to have definite, stated reason for going to the US. You will then apply for the type of visa that reflects this stated reason. In order to classify the types of foreign nationals on the basis of the reason they are visiting the US, the State Department of the US issues different types of visas. These visas are lettered from �A� all the way to �T�, with every type having subtypes. The A visa, for example, is for diplomats. If you want to go to the US in your function and capacity of an ambassador, public minister, diplomatic or consular officer, or an immediate family member (of all these diplomatic posts), you would need to apply for the A-1 visa. For our purposes, there are only four visas we need to concern ourselves with. They are the H1-B visa, J1 visa, the B1/B2 and the F1 visas. If you come across any other visa types in your USMLE journey, you may cheerfully ignore them. Sponsoring: A program is said to sponsor a visa if it will take responsibility for you once that visa is approved. This applies only to the J1 and H1-B visas. You need to go to the US in order to take your Step 2 CS exam as well as to attend the interviews. In order to do this, you will need a �visiting� visa. There are two types of visiting visas, the B1 and the B2. When you apply for these visas, your stated intention for coming to the US is for business (in case of the B1 visa) or for pleasure (in case of the B2 visa). You can apply to either one for the purpose of going to the US for the Step 2 CS and/or interviews. The B visa (be it B1 or B2) is the first visa you will need to apply for and this is where most of the visa problems you may have heard about arise. There are 3 types of B visas: A 6-month single entry visa � in which you�re allowed to go to the US once in a 6 month window period A 1-year double entry visa � in which you�re allowed to go to the US twice in a 1 year window period A 5-year multiple visa � in which you�re allowed to go come and go freely to the US within a 5 year window period. The reason it has become increasingly difficult for people to obtain a B visa is because of a long history of foreigners going to the US as a temporary �visitors� and then disappearing from the radar to stay and work illegally in the US. This has become a huge headache for the US State Department and Department of Homeland security, and in response, they have become increasingly suspicious of financially poor B-visa applicants from third world countries who want to visit the US as �tourists�. It is not surprising that the visa officers will reject the application for a B-visa on the grounds that the individual in question is considered a high-risk case who may not return from the US, but stay to work there illegally. Therefore, for quite a number of years now, applicants for B visas have the burden of proving to the visa officer that they do intend to return to their country after concluding their business in the US. The visa officer will assume that the applicant for the B visa is going to misuse his B visa if it is granted, and it is the responsibility (or �burden of proof�) of the applicant to convince him otherwise. This visa has, in recent years, become the most problematic for those wishing to go to the US for the Step 2 CS and/or interviews. It is on record that individuals who have taken both Step 1 and Step 2 CK (and scored very highly) who wish to go to the US for their Step 2 CS/Interviews have been rejected for the B visa . Naturally, this can be very devastating for the candidate, who by that stage has invested not only a lot of money, but time and great effort as well. After working and planning for years, their dream of going to the US for further training can be killed by a visa interview that lasts less than 5 minutes. There are certain factors that could help a candidate improve his chances of securing the B visas. The basic principle behind the factors, is strong ties to the home country. If an applicant has strong ties to his home country, it can be taken as proof that he will most probably return to his country when his business is done, and not stay back in the US illegally. Evidence of strong ties could include, proof of property and/or substantial assets in the home country, immediate family in the home country, or good socio-economic position in the home country, etc� Whatever convinces the visa officer that you have ties to your home country that you would not jeopardize by staying permanently (and illegally) in the US could improve your chances of getting the B visa. Note that I keep on using the words �could� or �can� when I talk about improving your chances. The reason is that the experiences of our IMGs applying for this visa demonstrate that there doesn�t seem to be any criteria that we can reliably use as a guide. People with good home country ties have been rejected, while others will poor country ties have been given the B visas. Similarly, people with great USMLE scores have been rejected while people with less-than-good scores have been given the visa. There is even a case of a bright young man who got 90s in both his Step 1 and Step 2 exam, went to the US on a B-visa to give his CSA exam, and came back. When the interview season started, his B-visa had expired and he applied for another B visa to go for this interviews but was rejected. Stories such as these have made the whole visa issue very uncertain. Most people just leave it to fate, or God�s will, and leave it at that. However, I don�t wish to give you the impression that the situation is hopeless. Far from it, many people still get the visa. Furthermore, a lot of the people rejected for the B visa the first time get it after the second, third or even fourth attempt. An initial rejection for the B visa is not the end of the story. You can definitely reapply. The only problem is that the processing for the visa can take several months, and an initial rejection can set your whole timetable back. In many cases, this usually means that the individual will lose the opportunity to participate in the match that year. It is therefore highly recommended that you apply for this visa as soon as possible in your USMLE process, so if you get rejected the first time, you can afford the time it takes to reapply. This is a good place to mention Electives. As I said previously, an elective may be clinical or research. In a research elective, you participate in a research study in a hospital or medical university. A clinical elective involves you observing (not actually doing anything) and studying medicine in the clinical environment of a hospital. In recent years, it has become clear that such an elective (especially the clinical one) helps tremendously in the whole USMLE process. For one thing, the elective experience is, in itself, a valuable addition to your CV. Furthermore, the visa obtained for going to such an elective is the B1 visa. Electives are offered to medical students, not graduates. Therefore, at the time of applying for such an elective, the individual will be enrolled in a medical college, which is a strong proof of �ties to home country�. This is perhaps why medical students going for electives have had a much easier time obtaining the B visa compared to medical graduates. Now, if the visa you obtain for your elective is a is a 5-year multiple, that means it will still be valid by the time you are ready to go to the US to give the Step 2 CS and go for interviews. Nevertheless, it does not automatically mean that all other visa hurdles are overcome, as we shall we in the section on J1 visas. The F-1 is a student visa and when granted, allows you to join a university or college in the US to pursue a certain degree. It is easier to get an F-1 visa approved than a B-1 visa. Therefore what we have seen happening in recent years (particularly in India), is doctors with visa problems applying to colleges/universities in the US to study for the one year Master of Public Health (MPH) degree. This MPH degree not only enhances an IMG�s credentials, but also allows the IMG to travel to the US. While the visa problem may be bypassed, the disadvantage of going by this route is the cost involved. Depending on the college/university, a one-year masters degree can cost anywhere from $5,000 to $40,000. Furthermore, if a doctor has yet to give his USMLE Steps, then it will become very difficult for him to study for both his MPH degree and his Steps. An alternative to applying for the F-1 on the basis of an MPH degree in a college/university is the Kaplan USMLE courses. These courses vary in duration with the longest lasting a year. If you enroll in a Kaplan USMLE course, you will be eligible to apply for the F-1 visa. A further, obvious advantage is that attending the Kaplan course mean you�ll be studying for the Steps. The downside is that the one-year course costs approximately $10,000. Along with the cost of the course will be the living expenses you�ll have to bear during your stay there. Step II - CS & Visa Issue In order to take the Step 2 CS exam, you need a B1/B2 visiting visa to travel to the US where this exam is conducted. These days, the key to getting a visiting visa is to provide demonstrable proof that you have business in the US you need to attend to. If you apply for the Step 2 CS exam, you will be mailed the registration receipt for the exam, and this will suffice for the �proof� needed. Currently, most candidates apply for the Step 2 CS exam after their Step 2 CK. This was usually around February or March of the year they were applying to ERAS. The problem with this is that these days, visa processing and approval can take up to 6 months and if you�re unlucky sometimes even longer. Therefore, a candidate applying in February/March for a visiting visa was at risk of getting it approved at a time when the interview season is over � causing him to miss his chance at a match that year. Since the Step 2 CS exam can now be given even by medical students, the logical thing to do is to apply for a visiting visa very early on in the USMLE process. Suppose, you apply for the visiting visa in January 2006, around the time you start studying for the Step 1. In that case, even if your visa application process takes up to a year, it will still come through in January 2007. Thereafter you can travel to the US when it is convenient for you, without having to worry about missing interview dates � which are still 9 months away. Applying very early for a visiting visa also gives you the opportunity to reapply if your application is rejected the first time (as it often is) and not miss your target Match year. Often people who were rejected the first, or even second time got approved in their third try. To illustrate: suppose you�re aiming to participate in the 2008 Match. Let�s also assume the visa processing time takes 6 months. If you apply in January 2006 and get rejected the first time in June 2006, you will reapply immediately that same month. If your application gets rejected a second time in December 2006, you will immediately reapply yet again. If you�re lucky, you�ll get approved the third time and be allowed to go to the US somewhere in the middle of 2007, where you�ll be right on time to take the Step 2 CS, Step 3 and attend your interviews. Visiting visas are granted to medical students more readily than medical graduates so the best time to apply might be in your final year of medical college/university. If you obtain a 5-year multiple visa while still a student, you don�t have to worry any further about visa problems when the time to take the interviews and Step 3 arrives, about two years later. On the other hand, let�s suppose as a final year student, you get only a 6-month or 1-year entry visa (and avail it to go to the US to take and pass the Step 2 CS). Such a visa would expire by the time you were ready to go for interviews and Step 3. In that case, after passing first the Step 2 CS, then Step 1 and Step 2 CK, you should immediately apply for your ECFMG certification and register for the Step 3 exam and apply for a visiting visa on the basis of your Step 3 registration receipt. It is hoped that having already previously received a visiting visa (even if was just a 6-month or 1-year duration), the chances of you getting a visa a second time to take your Step 3 and go for interviews will be good (although this may not always be the case). Even if this second visa is only a 6-month entry visa, it would be adequate to go to the US to take the Step 3 and attend interviews. The H1-B visa is given to �Specialty Occupations, DOD workers, and fashion models�. Plainly put, the H1-B is a work visa. It allows you to enter the US and use your professional credentials to earn a living. In order to do so, you need to secure an employment first, and in our case, the employer will be a hospital program where the doctor will also be trained. This also explains why IMGs who wish to be considered for a H1-B visa have to pass the Step 3 first. The Step 3 is evidence of your ability to practice medicine in an unsupervised setting. Before the program hires you, it wants proof you can do the job. Not all programs sponsor IMGs for H1-B visas so if you�re interested in getting an H1-B visa, you have to do your research and find out which ones do. In general community-based hospitals are more likely to sponsor H1-B than university-based hospitals but there are many exceptions. The H1-B visa is widely preferred by IMGs for the reason that it allows the IMG to file an application for a Green Card (a permanent residence status) in the US. In order to apply for a Green Card, your employer has to sponsor you for one. The number of residency programs that sponsor their H1-B workers for a green card is small, the reason being that the residency is a �training� position rather than an �employment� one. The H1-B is valid for 6 years. This allows IMGs on H1-B visas to apply for a job after their 3-year residency is over with another employer who will sponsor a green card for them. Since by the time you complete a residency, you�ll be a well-qualified doctor, getting jobs in such places is not too difficult. There are other clear advantages of the H1-B over the J1. Firstly, residents on the J1 visa have to overcome the hurdle of the �two year requirement� (see below) which is something H1-B residents have to worry about. Secondly, residents working on the H1-B visa can travel back to their own country (for vacations or whatever) freely, without having to renew this visa when returning to the US. By contrast, residents with the J1 visa who visit their country have to renew the J1 visa when they are returning to the US. There is always the possibility of the J1 renewal being rejected - it has happened. As a result, the J1 holders find themselves a less secure than the H1-B holders. Thirdly, once an application for an H1-B visa is made by the employer, it is almost never rejected by the American Embassy. The H1-B visa is issued with the presumption that the H1-B worker is filling a vital skilled worker gap for which an American worker of similar credentials cannot be found. Therefore, it is in the interest of the US to issue such a visa when an employer in the US asks for it. By contrast, the concept of the J1 visa, as we shall see, carries no particular influence on US interests, and as such can (and has been) rejected. The H1-B visa is applied for by your employer, not by you. When you been matched with a program that will sponsor you for a H1-B visa, it is up to them to apply for the H1-B visa on your behalf. In order to be eligible for H1-B sponsorship, you need to have your Step 3 result (passed, of course), no later than (and sooner if possible), March of the year the residency starts. This is important to ensure that the H1-B visa application has sufficient time to get processed before the residency actually begins. It can take as long as 6 months to process. However, a service called premium processing is in place which guarantees that your H1-B application will be processed in under 2 weeks for a fee of $1000 dollars. If you find a program that sponsors you for an H1-B visa, and the application is processed and approved in time, then you can go and join the program as a resident on the first of July of that year. In 1961, the US Congress passed an act called the �Mutual Educational and Cultural Exchange Act.� According to the US State Department: �The purpose of the Act is to increase mutual understanding between the people of the United States and the people of other countries by means of educational and cultural exchanges. International educational and cultural exchanges are one of the most effective means of developing lasting and meaningful relationships. They provide an extremely valuable opportunity to experience the United States and our way of life. Foreign nationals come to the United States to participate in a wide variety of educational and cultural exchange programs.� In order to come to the US for the purpose of �participating in educational and cultural exchange programs,� the J1 visa was created. Certain institutions were given the right to sponsor J1 visas. Of the many such institutions, many training hospitals were also included. A person coming into the US on a J1 visa would be an �exchange visitor�, i.e., he has come to acquire skills in the US that he will take back with him to his own country once the period of training is over. The underlying principle of the exchange program is that the US allows third world countries to benefit from Western expertise by allowing them to send professionals to be trained further for a fixed period of time. When this time is over, the professional will go back to his home country to share and spread the skills he has acquired. If this principle were actually applied, it would benefit the home country immensely, because every year we would have hundreds, if not thousands of highly trained doctors coming back to their country instead of going out. In order to ensure that the exchange visitors actually do go back home after the training is over, the J1 holder is subject to a Two-Year Foreign Residency Requirement. This requirement insists that the J1 holder return to his home country for at least two years after the period of training is over unless he receives an exemption for this requirement. If the J1 is seen by most IMGs as undesirable, it is mostly because they don�t wish to face the prospect of being forced to return to their own countries. The most common way the exemption to the 2-year requirement is met is to be employed in a medically underserved area in the US. What scares most doctors who try to exempt themselves from the 2-year requirement is that these �underserved� areas may be in the middle of nowhere. After all, the area would be medically underserved for a reason � few doctors want to practice there. Furthermore, you may not get the appointment to an underserved area in the first place, and if that happens to be the case, you will have no choice but to leave. The exemption from the 2-year requirement therefore is a huge source of worry for many doctors on the J-1 visa when the time to deal with this problem draws near. When you are matched with a program that sponsors the J1 visa, they will send you a letter of appointment. You will apply for a J1 visa at the American Embassy on the strength of this letter of appointment. Remember, the match occurs on the 3rd Wednesday of every March and the residency starts on the 1st of July, which is 3 and a half months away. A potentially serious problem arises here: three and a half months may not be enough time to process the J1 visa application. There is no premium processing system in place for the J1. Such an application can take as long as 6 months. Therefore, if it takes more than 3 and a half months, you�ll miss the start of your residency. This in fact is precisely what has been happening in the last few years. Many applicants, armed with a letter of appointment sponsoring a J1 visa have gone to the US Embassy only to find themselves months later in no-man�s-land their residency start date has come and gone while their J1 application is still pending. Whether the candidate lost the residency over this depended on the generosity of the program itself, but as can be expected, the increased trend of prolonged J1 processing time has tried the patience of many programs. The program suffers greatly itself, because it has to redistribute the existing workload on its already overworked resident population. This has led to a disturbing trend in that programs with bad J1-processing experiences have stopped accepting graduates from countries (like Pakistan) where potentially prolonged clearance of the J1 visas meant a possibility of missing the start of the residency. The program directors cannot be blamed for treating Pakistani applicants with some caution. Their primary responsibility is to their program, and they must do what is best for the program. If this means accepting less �high-risk� doctors into their program, then so be it. The delayed processing time of the J1 visa for some doctors is not the only problem to arise in the last few years. It appears that the J1 visa has been out-rightly rejected by the American Embassy. This perhaps is the most devastating blow of all. The very last hurdle is the J1 visa. After all the Step exams, all the interviews, all the hard work, money and time invested, the very last thing an IMG requires is for his J1 to be approved so he can go work in the US. It is not known how many doctors have faced such a predicament, but its rising incidence has prompted the Association of Pakistani Physicians of North America (APPNA) to write a petition to the US State Department in July of 2003 (when residencies started and the J1 visa status was apparent). The subject of the petition was �Significant Rise In The J1 Visa Refusals To Pakistani Phycisians�. The petition mentioned the following, among other, points: In the previous month of June 2003, there has been a significant rise in the refusal of J1 trainee visas to Pakistani physicians. These physicians have completed an exhaustive process of taking the required qualifying tests, have received ECFMG (Education Commission on Foreign Medical Graduates) certification, were interviewed and selected in a US Residency Program in an accredited training hospital, were issued the contracts by the hospital and had received the necessary paperwork from the ECFMG and the Pakistani Government for an Exchange Visa Program. The final step was to get a J1 visa from the US Embassy in Islamabad to proceed to USA for training. Traditionally the residency-training year starts on July 1st of every year. We know of at least twenty-five such physicians who were turned down at the eleventh hour. There are probably many more. The reasons given to the visa applicants, through the information received by us, were varied, but universally flawed. Reasons ranged from unsubstantiated technical reasons, to "USA does not need any more doctors", to not enough social ties for the individual to come back to Pakistan. It is to be noted that the J1 visa is issued specifically for the purpose of returning to the country of origin. We strongly believe that all the reasons given (for rejecting the J1 visas) are trivial at best and give the impression of a concerted policy to deny visas to aspiring physicians from Pakistan. We believe that the policies are not enforced with same level of strictness to physicians from countries other than Pakistan. As such they are discriminatory. (This) will also deter the future training program directors to select physicians from Pakistan as they may again face similar denials of visas. At the time of writing this manual, the direction of this trend is unclear. It will be evident from the Match of 2005 whether the situation has worsened or improved since it was first noticed in 2003. usmle step 1 exam dates 2021 pakistan. step 1 2021 dates. usmle step 1 2020 dates

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