

2008 ACSM Workshop Application for ACSM Certified Professionals

ACSM Health/Fitness Instructor[®], ACSM Exercise Specialist[®]

STEP 1

Please indicate your name as you would like it to appear on your contact information.

ACSM files will reflect this name and address. Please do not abbreviate.

Dr. Mr. Ms. Mrs.

First Name M.I. Last Name

Home Work _____
Preferred Mailing Address for all ACSM materials

City State Zip Code

Business Telephone Home Telephone E-mail Address

Date of Birth: _____ Gender: Male Female

Special Accommodations Required: Yes No

University attended Degree and Major relevant to requirements Year

Other current certifications _____

Site Location Date

For a current list of workshops, please visit www.acsm.org/register

STEP 2 Workshop/CEC Course Options

Select the ACSM workshop	Include payment*		
<input type="checkbox"/> ACSM Health/Fitness Instructor [®] <input type="checkbox"/> ACSM Exercise Specialist [®]	<small>(THE WORKSHOP AND THE CEC COURSE ARE PRESENTED BY ACSM EXPERTS AND ARE A GREAT WAY TO EARN AND MAINTAIN AN ACSM CERTIFICATION.)</small>		
	<input type="checkbox"/> \$195 2-Day Workshop (Applies to HFI or ES)	<input type="checkbox"/> \$140 1-day CEC Course "Weight Management for the Health and Fitness Professional" or "Behavior Change Strategies for Optimal Client Outcomes" <small>(COURSE NOT AVAILABLE AT ALL SITES)</small>	<input type="checkbox"/> Total Payment \$ _____ ACSM ID _____

*Registrations with payment must be received, faxed, or submitted online before, or prior to, the enrollment deadline. Enrollment deadline dates can be found at www.acsm.org/register.

STEP 3 Include Payment

____ Enclosed with application is a check/money order payable to ACSM (ACSM Fed ID# 23-6390952). All payments must be in U.S. dollars (\$25 fee for returned checks).

____ Charge above fees to: MasterCard VISA

All 16 numbers must be given

Signature authorizes ACSM to charge credit card

_____/_____
Expiration Date

Mail or fax the certification application to:
ACSM National Center
Certification Department 6022
Carol Stream, IL 60122-6022 USA
Fax: (317) 634-7817



I, by the signature affixed below, understand that continued CPR certification is a necessary component of, and requirement for, valid ACSM certification; and I confirm that I have met all of the minimum requirements for this level of credential and will provide proof if necessary. I have completed the application to the best of my knowledge, and the information is accurate and true. I have read, understand, and agree to the registration transfer and cancellation agreement (see page 13 of the CRC catalog).

Signature of applicant

*Payment or purchase order must accompany all applications.

For information or questions about this form call 317-637-9200, ext. 115. ACSM is located at 401 West Michigan St., Indianapolis, IN 46202-3233