

American College of Sports Medicine — Certified Clinical Exercise Physiologist®

Clinical Experience Setting: fill out the following to the best of your ability. Please type responses before saving or printing to send to ACSM. Please fill in the type of setting you were/are in, and the approximate number of hours you had actual contact with the disease/condition performing the tasks listed across the top.

Listing of Hours: only list actual hours worked. If a person has multiple conditions it still only counts as one hour and NOT one hour for each condition. See example for more details.

Type of Experience: Please designate with a P (Professional), S (Student/Internship) or V (Volunteer) in the section provided.

Type of Setting: Hospital (H), Outpatient Clinic (OC), Exercise Testing Lab (ET), Wellness/Fitness/Recreation Center (RC), or Other (please describe type of setting such as: resort, spa, personal training studio, etc.)

Name of Facility: Please type in the name of the facility where you received your experience/training.

Multiple Facilities for Same Disease/Condition: If you attended multiple facilities to get experience in the same disease/condition, please type both in the same space separated by a dash (-), comma (,), colon (:), or semi-colon (;).

Disease/Condition	Patient Assessment	Exercise Testing	Exercise Prescription	Exercise Training and Leadership	Exercise Education/ Behavior Change	Supervisor Name, Phone, Email
Cardiovascular	Dates	Dates	Dates	Dates	Dates	Name
	Setting	Setting	Setting	Setting	Setting	
	Type	Type	Type	Type	Type	Phone
	Name of facility	Name of facility	Name of facility	Name of facility	Name of facility	
						Email
	Hours	Hours	Hours	Hours	Hours	(please list supervisors from each location)
Pulmonary	Dates	Dates	Dates	Dates	Dates	Name
	Setting	Setting	Setting	Setting	Setting	
	Type	Type	Type	Type	Type	Phone
	Name of facility	Name of facility	Name of facility	Name of facility	Name of facility	
						Email
	Hours	Hours	Hours	Hours	Hours	(please list supervisors from each location)
Metabolic	Dates	Dates	Dates	Dates	Dates	Name
	Setting	Setting	Setting	Setting	Setting	
	Type	Type	Type	Type	Type	Phone
	Name of facility	Name of facility	Name of facility	Name of facility	Name of facility	
						Email
	Hours	Hours	Hours	Hours	Hours	(please list supervisors from each location)

* P - professional work experience S - student internship V - volunteer experience

(continued on the next page)

Disease/Condition	Patient Assessment	Exercise Testing	Exercise Prescription	Exercise Training and Leadership	Exercise Education/ Behavior Change	Supervisor Name, Phone, Email
Orthopedic/ Musculoskeletal	Dates	Dates	Dates	Dates	Dates	Name
	Setting	Setting	Setting	Setting	Setting	
	Type	Type	Type	Type	Type	Phone
	Name of facility	Name of facility	Name of facility	Name of facility	Name of facility	Email
	Hours	Hours	Hours	Hours	Hours	(please list supervisors from each location)
Neuromuscular	Dates	Dates	Dates	Dates	Dates	Name
	Setting	Setting	Setting	Setting	Setting	
	Type	Type	Type	Type	Type	Phone
	Name of facility	Name of facility	Name of facility	Name of facility	Name of facility	Email
	Hours	Hours	Hours	Hours	Hours	(please list supervisors from each location)
Immunologic/ Hematologic	Dates	Dates	Dates	Dates	Dates	Name
	Setting	Setting	Setting	Setting	Setting	
	Type	Type	Type	Type	Type	Phone
	Name of facility	Name of facility	Name of facility	Name of facility	Name of facility	Email
	Hours	Hours	Hours	Hours	Hours	(please list supervisors from each location)
Cancer	Dates	Dates	Dates	Dates	Dates	Name
	Setting	Setting	Setting	Setting	Setting	
	Type	Type	Type	Type	Type	Phone
	Name of facility	Name of facility	Name of facility	Name of facility	Name of facility	Email
	Hours	Hours	Hours	Hours	Hours	(please list supervisors from each location)

Additional Comments (Please add any additional comments about your clinical experience)

* P - professional work experience S - student internship V - volunteer experience

I confirm that the information above accurately summarizes my clinical experience in preparation to qualify for the CEP® examination. I understand that falsification of this information could result in the revocation of the CEP® credential.

Signature of Applicant _____