2020 ACSM Certified Clinical Exercise Physiologist® Application

Mail the certification application to:

ACSM National Center
PO Box 1440
Indianapolis, IN 46206-1440 USA
Fax: (317) 634-7817

First-time ACSM-CEP candidates must submit all of the following to be considered for the exam:

- Application
- One official copy of your university transcript noting the degree completion
- A summary description of the program of study with the list of required courses with course descriptions as written in the university catalog
- A completed clinical experience documentation form (see next page)
- Copy of BLS or CPR for the professional rescuer certification

Once approved a candidate can register to take exam, by visiting www.pearsonvue.com/acsm

If you do not meet the ACSM-CEP eligibility criteria, exam fees will be fully refunded and you may re-apply once you fulfill the requirements.

Please indicate your name as you would like it to appear on your certificate. ACSM files will reflect this name and address. Please do not abbreviate.

❑ Dr. ❑ Mr. ❑ Ms. ACSM ID: _____

First Name _____ M.I. _____

Last Name _____

❑ Home Address _____

City _____ State _____ Zip _____

❑ Work Address _____

City _____ State _____ Zip _____

Business Telephone _____

Home Telephone _____

Email Address _____

Date of Birth_____ Gender: ❑ Female ❑ Male ❑ Non-Binary ❑ Prefer not to say

Special Accommodations Required _____

University Attended _____

Degree and Major relevant to requirements _____ Year _____

Have you graduated? _____

Other current certifications _____

Candidates

- Clinical exercise physiology master's degree and 600 hours of documented hands-on experience.

OR

- Exercise Science, Exercise Physiology bachelor's degree and 1,200 hours of documented hands-on experience.
- Current Certification as a Basic Life Support Provider or CPR for the Professional Rescuer

Exam cost through December 31, 2020 (check all that apply)

Exam	❑ $349.00
ACSM Members	❑ $279.00
CAAHEP MS program graduate (CoAES)	❑ $210.00

*No other discounts

Total ❑ $_____

Total $_____

❑ Enclosed with the 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).

Please charge above fees to my
❑ MasterCard® ❑ Visa® ❑ Discover® ❑ American Express®

Card number |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Expiration Date: |__|__|/|__|__| Security Code: |__|__|

_____

Signature authorizes ACSM to charge credit card

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acsm CERTIFICATION

Signature of Applicant _____ Date _____

I, by the signature affixed above, 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**, which can be found in the *ACSM Get Certified Guide*.

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 Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Name Phone Email (please list supervisors from each location)
Pulmonary	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Name Phone Email (please list supervisors from each location)
Metabolic	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Name Phone Email (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 Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Name Phone Email (please list supervisors from each location)
Neuromuscular	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Name Phone Email (please list supervisors from each location)
Immunologic/ Hematologic	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Name Phone Email (please list supervisors from each location)
Cancer	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Dates Setting Type Name of facility Hours	Name Phone Email (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 ACSM-CEP® examination. I understand that falsification of this information could result in the revocation of the ACSM-CEP® credential.

Signature of Applicant _____