Appendix B

Special Accommodations Request Form

Request for Testing Accommodations

The American College of Sports Medicine (ACSM) complies with the Americans with Disabilities Act of 1990 (ADA). To ensure equal opportunities for all qualified persons, ACSM will make reasonable testing accommodations for certification candidates when appropriate and consistent with such legal requirements. ACSM will consider requests for testing accommodations related to any ACSM Certification exams from certification candidates with a documented disability that substantially limits the candidate's sensory, manual, speaking or other functional skills, including a disability that impairs significantly the candidate's ability to arrive at, read or otherwise complete the examination. These accommodations can include additional time to complete the exam or use of approved auxiliary aids.

ACSM requires that each candidate requesting a testing accommodation complete and submit this form by email within 30 days prior to the scheduling of a certification exam. A physician or other qualified professional who has made an individualized assessment related to the candidate's disability must provide the required information concerning the disability and the requested accommodation. A qualified professional is a licensed or otherwise properly credentialed individual who possesses expertise in the disability for which an accommodation is sought. The information and any documentation that the candidate provides regarding his/her disability and the need for accommodation(s) will be treated as confidential.

NOTE: Candidates may take breaks taken at testing centers at any time during the exam; however, the exam timer will continue to run during breaks. Therefore, extended time should be considered for candidates who require frequent or extended breaks related to their disability.

NOTE: Accommodations cannot be added to an already-scheduled exam. Please do not schedule your exam until your accommodations are approved. If you have already scheduled your exam, please CANCEL it and follow the instructions after accommodations are approved.

Certification Candidate Information

Candidate's Name: (First Middle Initial Last)
ACSM ID:
Home Address:
City, State, Zip:
Telephone Number:
Email Address:

Certification Past Accommodations History

Have you previously received test accommodations during any of the following?

Certification or Licensure Examinations	❑ Yes	❑ No
Vocational Training or Higher Education	❑ Yes	❑ No
Elementary or Secondary School	❑ Yes	❑ No

NOTE: For each "YES" response above, please attach a detailed description of your accommodation history to this form, including but not limited to:

- *The disability related to the accommodation,*
- *The accommodation provided,*
- *The organization providing the accommodation,*
- *The name of the examination for which the accommodation was provided,*
- *The date the examination and accommodation were provided. Please indicate if the candidate took the exam multiple times but did not receive accommodations for all administrations of the exam.*

Qualified Professional Providing Diagnosis

Professional's Name:
(First Middle Initial Last)

Business Address:

City, State, Zip:

Telephone Number:

Email Address:

Professional Title:
(e.g., Medical Doctor, Licensed Psychologist)

License Number and State Issuing License:

Professional Credential and Organization Issuing Credential:

Description of Disability

Disability Related to the Accommodation Request:

Date of Most Recent Professional Diagnosis:

Diagnostic Methods Used:

Diagnostic Results:

Requested Accommodation(s)

Please list all accommodations you are requesting

❑ 1.5 x Exam Time	❑ Magnified Screen Text	❑ Reader
❑ 2.0 x Exam Time	❑ Separate Room	❑ Recorder
❑ Enlarged Font	❑ Other: (please describe)	

Certification Exam

Please check the certification exam you would like accommodations for

❑ ACSM Certified Personal Trainer	❑ ACSM Certified Group Exercise Instructor
❑ ACSM Certified Exercise Physiologist	❑ ACSM Certified Clinical Exercise Physiologist
❑ ACSM/NPAS Physical Activity in Public Health Specialist	

Signature of Qualified Professional:

By signing below, I verify that the information provided on this form and in the attached accommodations plan and documentation (if any) is complete and accurate to the best of my knowledge.

Signature of Qualified Professional Date

Signature of Candidate:

By signing below, I verify that the information provided on this form and in the attached accommodations plan and documentation (if any) is complete and accurate to the best of my knowledge. I authorize the release and disclosure of diagnostic information by health care providers, or other professionals having such information, for the purpose of allowing ACSM to make a determination regarding my request for a testing accommodation. I understand that ACSM will employ reasonable methods to help ensure that the information provided regarding my disability and request for accommodation is treated as confidential.

Signature of Candidate Date

Submit the completed form and attachments to certification@acsm.org.