Special Accommodations Request Form

Name: ___________________________ Date: ________________

Address: ___________________________________________________

City: ___________________________ State: ___________ Zip Code: __________________

Home Phone: ___________________________ Email Address: ___________________________

Exam Type: _____ Certified Personal Trainer _____ Certified Group Exercise Instructor

_____ Certified Exercise Physiologist _____ Clinical Exercise Physiologist

_____ Certified Inclusive Fitness Trainer _____ Cancer Exercise Trainer

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

The American College of Sports Medicine (ACSM) wishes to ensure that no individual with a disability is excluded, denied services, segregated, or otherwise treated differently from other individuals because of the absence of auxiliary aids and services.

If you need any of the auxiliary aids or services identified in the Americans with Disabilities Act, please contact ACSM’s office at (317) 637-9200.

IF YOU NEED ASSISTANCE YOU MUST:

1. Notify the ACSM National Office in writing by sending in this form to the ACSM National Center no later than 14 business days prior to your desired exam date.

2. Include written verification of your disability from a professional.

Description of the type of disability:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Special equipment/situation requested:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Send this form and written verification of disability to:

American College of Sports Medicine
Attn: Certification
401 W. Michigan St.
Indianapolis, IN 46202
PHONE: (317) 637-9200
FAX: (317) 634-7817

For Office Use Only:

Reviewed: ___________________________

Accepted: ___________________________

Declined: ___________________________

Notified: ___________________________