ACSM Certification Special Accommodations Request Form

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Email Address: _____

Exam Type:
____ Certified Personal Trainer
____ Certified Exercise Physiologist
____ Registered Clinical Exercise Physiologist
____ Certified Inclusive Fitness Trainer
____ Certified Group Exercise Instructor
____ Certified Clinical Exercise Physiologist
____ Cancer Exercise Trainer
____ Physical Activity in Public Health Specialist

Date and location of exam (if previously scheduled): _____

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 30 days **before** the date of the workshop/certification, if not sooner.
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
EMAIL: certification@acsm.org

For Office Use Only:

Reviewed: _____

Accepted: _____

Declined: _____

Notified: _____