2013 ACSM Certification Workshop Application for NIRSA Members

STEP 1

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

❑ Dr. ❑ Mr. ❑ Ms. ❑ Mrs.

First Name M.I Last Name

❑ Home ❑ Work

Preferred Mailing Address for all ACSM materials

City State Zip Code

Business Telephone Home Telephone E-mail Address

Date of Birth: _____ Gender: ❑ Male ❑ Female

Special Accommodations Required: ❑ Yes ❑ No

University attended Degree and Major relevant to requirements Year

Other current certifications

Workshop Location City State Workshop Dates

For a current list of workshops, please visit www.acsm.org/register

STEP 2 Workshop

Save 15%

	3-Day Workshop		1-Day Workshop		2-Day Workshop		CEC Course (Not available at all sites)		2-Day Workshop and CEC Course	
Credential	**Fee**	**Your Cost**	**Fee**	**Your Cost**	**Fee**	**Your Cost**	**Fee**	**Your Cost**	**Fee**	**Your Cost**
CPT	❑$337.50		❑$116.10							
HFS					❑$225		❑$126		❑$300.60	
CES					❑$225		❑$126		❑$300.60	
RCEP					❑$225					
***Early-Bird Deadline**					❑-$25					
Total										

*Registrations with payment must be received, faxed, or submitted online 45 days prior to first day of event.

STEP 3 Include Payment

❑ 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

I, by the signature affixed below, 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.

Signature of applicant

*Payment or purchase order must accompany all applications.

Mail or fax the certification application to:

ACSM National Center
Certification Department 6022
Carol Stream, IL 60122-6022
Fax: (317) 634-7817

For information or questions about this form call 317-637-9200, ext. 115. ACSM is located at 401 West Michigan St., Indianapolis, IN 46202-3233