

# American College of Sports Medicine – ACSM Certified Clinical Exercise Physiologist Clinical Hour Verification Form

ACSM ID Number \_\_\_\_\_

Dr.  Mr.  Ms.  Mrs.

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work: \_\_\_\_\_ Home: \_\_\_\_\_ Email: \_\_\_\_\_

1. Please provide as accurate assessment as possible of your total clinical experiences up to 500 hours. Only hours associated with exercise assessment, prescription, counseling and education in which you assisted or played a direct role in providing services will be accepted. The site supervisor refers to the contact person who supervised your work or internship experience. You should notify this person that we may contact him/her to verify your practical experience.
2. In addition to this form, please submit letters from each supervisor regarding our clinical experience. It is recommended that these letters do not exceed 500 words.

	Total hours earned	Dates of experience	Candidate job title (specify role)	Organization	Supervisor name	Phone number and email
<b>Site 1</b> <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> V						
<b>Site 2</b> <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> V						
<b>Site 3</b> <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> V						
<b>Site 4</b> <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> V						

Please check the appropriate letter. P - professional experience S - student internship V - volunteer experience (any non-work or school related experience)

I confirm that the information above accurately summarizes my clinical experience. I understand that falsification of this information could result in the revocation of the ACSM Certified Clinical Exercise Physiologist credential.

Signature of applicant: \_\_\_\_\_ Date: \_\_\_\_\_

