MWACSM CERTIFIED INDIVIDUAL OF THE YEAR AWARD APPLICATION

Category: HEALTH FITNESS PROFESSIONAL ______

(check one) CLINICAL EXERCISE PROFESSIONAL ______

Applicants Name: ____

Address: ____

City: __________________________ State:________ Zip:__________

Work affiliation: ____

Supervisor/Superior contact: ____

Phone: __________________________ Email: __________________________

Years worked as ACSM certified individual: ____

Years work in current position: ____

Previous positions: ____

Accomplishments (please list below and provide a narrative of each on a separate page):

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(Use another page if necessary)

In addition to the information required above, please consider letters of endorsement from the applicant's peers, patients, clients or others.

Enclosed are letters from (check all that apply):

______ Peer(s)

______ Patient(s)/Client(s)

______ Superior(s)/Supervisor(s)

______ Other Please list: ____

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