*ARP/ACSM Recertification Renewal Form 2016*

*At the time of recertification, you are only requested to send this completed form to ACSM for recertification or renew online at http;//certification.acsm.org/. ACSM asks that you keep track of all your ringside medicine CME and only submit documentation proof if audited.*

**Please fill in the information below. This information will be used for all ACSM mailings.**

ACSM ID Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Certificate Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Middle Initial

Address: \_\_\_Home \_\_\_Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Required number of accredited “ringside medicine” CME in a 3-year cycle is 12 credits

Accredited “ringside medicine” CME includes but is not limited to the Association of Ringside Physicians Annual Conference

**Course Date # of CME**

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**Renewal Fees:** There is no renewal fee if submitted prior to the renewal date. **Pay the late fee of $25 if renewing *after* your certification has expired.**

\_\_Cash/Check Enclosed – ACSM Fed ID # 23-69-0952 ($25 fee for all Returned Checks

\_\_Mastercard \_\_VISA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

\_\_AMEX \_\_Discover CC Number Exp. Date Sec Code

By signing below, I understand that continuing education credits are a necessary component of , and requirement for, valid ARP/ACSM Certification/Registration. By sending in this form, I confirm that I meet all requirements to renew the credential of ARP/ACSM Certified Ringside Physician and will provide documentation of all CME if requested. I have completed the above application to the best of my knowledge and the information is accurate and true. I authorize the ACSM to charge my credit card if I owe a late fee.

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Signature Date

Mail with payment (if needed) to the ACSM National Center, Department 6022, Carol Stream, IL 60122-6022

Or email to [kwebster@acsm.org](mailto:kwebster@acsm.org) or fax to 317-634-7817