ACSM/ARP CERTIFIED RINGSIDE PHYSICIAN℠ Examination Application

Mail the certification application or fax to:

ACSM National Center
Attn: Certification
PO Box 1440
Indianapolis, IN 46206-1440
Email: arpcertification@gmail.com
Fax: (844) 329-2771

First-time candidates must submit all of the following to be considered for the exam:

- **Application**
- **Copy of your**
  - **Medical school diploma**
  - **Current State/Country medical license**
- **Two forms of recommendation (see attached forms)**
- **A completed clinical experience documentation form, to be completed by state/country athletic commission (see attached form)**
- **Copy of Board Certification Certificate or documentation of board eligibility. If this is not applicable, a written explanation of why not.**

Once approved a candidate will be provided with a voucher number and can register to take exam, by visiting www.pearsonvue.com/acsm

For exam deadlines, see the box in the upper right hand corner.

If you do not meet the eligibility criteria, only your exam fee will be fully refunded and you may re-apply once you fulfill the requirements.

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

Extensions past the voucher code expiration must be requested in writing. If an extension is granted, an administration fee may apply.

First Name _____ M.I. _____

Last Name _____

☐ Home Address _____

City _____ State _____ Zip _____

☐ Work Address _____

City _____ State _____ Zip _____

Business Telephone _____

Home Telephone _____

Email Address _____

Date of Birth _____ Gender _____ Special Accommodations Required _____

Medical School Attended _____

MD/DO _____ Year _____ Specialty _____

Candidates

- He/She must have a M.D. or D.O. degree or foreign medical degree equivalent
- He/She must have provided ringside event coverage for a minimum of three professional cards with at minimum of fifteen total fights or five amateur cards with a minimum of 30 total fights.
- He/She must be licensed and be in good standing with the licensing body authority, (e.g., state, country, etc.) in which he/she is a ringside physician in for a minimum of two years. This includes being up to date on required CME by his/her licensing body authority.
- He/She must provide 2 forms of recommendation from the following sources: State/Country athletic board commissioner, local boxing committee, or another ringside physician. Please use the forms provided with this application.
- If applicable he/she must be board certified/eligible in his/her primary medical specialty (e.g., Family Medicine, Emergency Medicine, Orthopaedics, etc.).

Exam Cost through December 31, 2016

Check all that apply

Exam ☐ $299.00

ACSM/ARP Members ☐ -$60.00

Total $_____

❑ 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

Mail or email the certification application to:

ACSM National Center
PO Box 1440
Indianapolis, IN 46206-1440 USA
Email : arpcertification@gmail.com

Signature of Applicant _____ Date _____

I, by the signature affixed above, 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, which can be found in the ACSM Get Certified Guide.

Event Coverage Documentation

(To be completed by state/country state athletic commission)

Physician Name _____

The above physician is a current candidate to become a Certified Ringside Physician through the American College of Sports Medicine and Association of Ringside Physicians. In order for a physician to be eligible for this qualification, he/she must have experience in a minimum amount of ringside event coverage. He/She must have provided ringside event coverage for a minimum of three professional cards with a minimum of fifteen total fights or five amateur cards with a minimum of 30 total fights.

Has the above physician provided the minimum amount of ringside event coverage?

[ ] Yes [ ] No

Is the above physician in good standing with the state or country commission where will be working?

[ ] Yes [ ] No

_____ _____

Signature Date

_____ _____

Print Name State/Country Athletic Commission

_____

Position

Certified Ringside Physician

Recommendation Form

Physician Name _____

The above physician is a current candidate to become a Certified Ringside Physician through the American College of Sports Medicine and Association of Ringside physicians. This physician has asked you to help them in this process by filling out this form. Please indicate your relationship to this physician and how long you have approximately known him/her. Please also include a comment or two about why you believe this physician should be a Certified Ringside Physician.

Relationship to the candidate

[ ] Ringside Physician Colleague

[ ] State/Country Athletic Board Member

[ ] Other_____

How long have you known the candidate:_____

Comments

_____

_____

_____

_____

_____

_____ _____

Signature Date

_____ _____

Print Name State or Country of Employment

Certified Ringside Physician

Recommendation Form

Physician Name _____

The above physician is a current candidate to become a Certified Ringside Physician through the American College of Sports Medicine and Association of Ringside Physicians. This physician has asked you to help them in this process by filling out this form. Please indicate your relationship to this physician and how long you have approximately known him/her. Please also include a comment or two about why you believe this physician should be a Certified Ringside Physician.

Relationship to the candidate

[ ] Ringside Physician Colleague

[ ] State/Country Athletic Board Member

[ ] Other_____

How long have you known the candidate:_____

Comments

_____

_____

_____

_____

_____

_____ _____

Signature Date

_____ _____

Print Name State or Country of Employment

Association of Ringside Physicians

Online Certified Ringside Physician Listing

Application Form

Please complete the following information to be used in the Association of Ringside Physicians online database. The information you provide below will be disseminated by electronic means on ARP's website, www.associationofringsidephysicians.org.

By submitting this form, you have given permission for your contact information to be published on ARP's website. Please return this completed form to ARP by fax (844) 329-2771 or mail to ARP National Center, Certification Department, 207 E Ohio St, Ste. 252, Chicago, IL 60611-3238. For questions concerning this application, please email arpcertification@gmail.com.

All information provided below will be published in the ARP website listing for credentialed ringside physicians. By joining this online service, you will be able to promote yourself as a qualified professional, allowing prospective clients to locate the expert of their choice.

FIRST NAME:_____ MIDDLE INITIAL: _____ LAST NAME:_____

Certification ID#: _____ EMAIL: _____

ADDRESS (line1):_____

ADDRESS (line2):_____

CITY:_____ STATE: _____ ZIP CODE: _____

BUSINESS PHONE: _____

SIGNATURE: _____ DATE: _____

I state that all information contained on this form is true and I give ARP the right to verify my credentials. By signing above, I acknowledge that this information will be made available to the public. I understand that I will be disqualified from participating in the ARP online certified professional listing if I have given false or misleading information and if my credential becomes invalid (recertification has not been completed). I also understand that ARP has the right to revoke my participation in the ARP online certified professional listing for any reason whatsoever.
