ACBSP™ FIELD DOCTOR VERIFICATION FORM

All fields, excluding the signature field, of this form may be completed on computer and then saved to print and sign.

NAME: _____PHONE:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

OFFICE PHONE: _____ALT. PREFERRED PHONE: _____

CCSP® Cert. Number: _____

SPORTS DIPLOMATE COLLEGE(s) ATTENDED: _____

_____

PRACTICAL EXPERIENCE VERIFICATION

I verify that the information that I have submitted concerning my practical experience hours is true and correct. I understand that if any false information is included my postgraduate certification may be withheld.

SIGNED: _____ DATE:_____

TYPE NAME: _____

Please submit to:
Email: info@acbsp.com
Fax: (888) 419-9990
Mail: ACBSP
15954 Jackson Creek Pkwy,
Ste. B543
Monument, CO 80132