

APPLICATION

CERTIFIED SPORTS FIELD MANAGER (CSFM) PROGRAM

Mr. Mrs. Miss Ms.

NAME _____

CURRENT TITLE _____

DATE CURRENT EMPLOYMENT STARTED: MONTH _____ DAY _____ YEAR _____ TO PRESENT

ARE YOU AN STMA NATIONAL MEMBER? _____ MEMBERSHIP NUMBER _____

ARE YOU AN STMA CHAPTER MEMBER? _____ CHAPTER(S) _____

HAVE YOU PREVIOUSLY APPLIED FOR CERTIFICATION OR BEEN CERTIFIED? _____

IF SO, DATE(S) OF PREVIOUS APPLICATION OR CERTIFICATION _____

EMPLOYER NAME AND ADDRESS

NAME _____ IMMEDIATE SUPERVISOR _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____ E-MAIL _____

HOME ADDRESS

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____ E-MAIL _____

PREFERRED ADDRESS FOR ALL CORRESPONDENCE IS: WORK _____ HOME _____

PLEASE DESCRIBE YOUR DUTIES AND RESPONSIBILITIES FOR YOUR CURRENT EMPLOYMENT:

(ATTACH ADDITIONAL PAGES IF NECESSARY)

HOW MANY MONTHS PER YEAR DO YOU WORK FULL TIME AT THIS POSITION? _____

HOW MANY HOURS PER WEEK DO YOU WORK AT THIS POSITION? _____

NOTE: A resume must accompany this application form.

Equal Opportunity Guidelines apply to all applicants. There will be no preference, limitation, specification or discrimination based on race, color, religion, age, sex, marital status, disability or national origin.

PRIOR RELEVANT EMPLOYMENT HISTORY

A. FACILITY OR COMPANY _____ Phone _____

CITY, STATE _____ POSITION TITLE _____

INCLUSIVE DATES OF EMPLOYMENT: FROM _____ TO _____

NAME OF IMMEDIATE SUPERVISOR _____ TITLE OR POSITION _____

IF SUPERVISORY POSITION, GIVE PERCENTAGE OF TIME YOU DEVOTED TO ACTUAL MANAGEMENT OPERATIONS.
_____ %

HOW MANY MONTHS PER YEAR DID YOU WORK FULL TIME AT THIS POSITION? _____

HOW MANY HOURS PER WEEK DID YOU WORK AT THIS POSITION? _____

PLEASE DESCRIBE YOUR DUTIES AND RESPONSIBILITIES FOR YOUR EMPLOYMENT IN THIS POSITION:

B. FACILITY OR COMPANY _____ Phone _____

CITY, STATE _____ POSITION TITLE _____

INCLUSIVE DATES OF EMPLOYMENT: FROM _____ TO _____

NAME OF IMMEDIATE SUPERVISOR _____ TITLE OR POSITION _____

IF SUPERVISORY POSITION, GIVE PERCENTAGE OF TIME YOU DEVOTED TO ACTUAL MANAGEMENT OPERATIONS.
_____ %

HOW MANY MONTHS PER YEAR DID YOU WORK FULL TIME AT THIS POSITION? _____

HOW MANY HOURS PER WEEK DID YOU WORK AT THIS POSITION? _____

PLEASE DESCRIBE YOUR DUTIES AND RESPONSIBILITIES FOR YOUR EMPLOYMENT IN THIS POSITION:

C. FACILITY OR COMPANY _____ Phone _____

CITY, STATE _____ POSITION TITLE _____

INCLUSIVE DATES OF EMPLOYMENT: FROM _____ TO _____

NAME OF IMMEDIATE SUPERVISOR _____ TITLE OR POSITION _____

IF SUPERVISORY POSITION, GIVE PERCENTAGE OF TIME YOU DEVOTED TO ACTUAL MANAGEMENT OPERATIONS.
_____ %

HOW MANY MONTHS PER YEAR DID YOU WORK FULL TIME AT THIS POSITION? _____

HOW MANY HOURS PER WEEK DID YOU WORK AT THIS POSITION? _____

PLEASE DESCRIBE YOUR DUTIES AND RESPONSIBILITIES FOR YOUR EMPLOYMENT IN THIS POSITION:

(ATTACH ADDITIONAL PAGES IF NECESSARY FOR EMPLOYMENT DESCRIPTION AND/OR FOR ADDITIONAL RELEVANT POSITIONS)

MEMBERSHIP IN OTHER PROFESSIONAL ORGANIZATIONS: _____

CERTIFICATION/ LICENSE CURRENTLY HELD: _____

I HEREBY ATTEST THAT ALL THE SUBMITTED INFORMATION IS CORRECT; FURTHER I AUTHORIZE STMA TO MAKE ANY INQUIRIES DEEMED NECESSARY TO ASCERTAIN MY ELIGIBILITY FOR CERTIFICATION, INCLUDING VERIFICATION OF MY EMPLOYMENT.

I UNDERSTAND THAT THE FEE OF \$ _____ U.S. (STMA MEMBER) OR \$ _____ U.S. (NON-MEMBER), WHICH MUST ACCOMPANY THIS APPLICATION, IS NON-REFUNDABLE.

I UNDERSTAND THAT FALSIFICATION ON THIS APPLICATION AT ANY TIME THAT IT IS DISCOVERED IS GROUNDS FOR APPLICATION REJECTION OR CERTIFICATION REVOCATION.

I UNDERSTAND THE PROCESSING OF THIS APPLICATION TAKES APPROXIMATELY FOUR (4) WEEKS. AT THAT TIME I WILL RECEIVE NOTIFICATION OF EITHER REJECTION, OR ACCEPTANCE OF MY APPLICATION AS AN APPLICANT IN THE CERTIFICATION PROGRAM.

MAKE CHECK PAYABLE TO "STMA CERTIFICATION PROGRAM".

DATE OF APPLICATION _____ **PRINT NAME** _____

SIGNATURE _____

NOTICE: UPON ANY REJECTION OF AN APPLICATION, THE REJECTED APPLICANT MAY, WITHIN THIRTY (30) DAYS OF THE NOTICE OF REJECTION, MAKE AN APPEAL DIRECTLY TO THE STAFF CERTIFICATION COORDINATOR THROUGH TELEPHONE CONTACT. SHOULD THE ISSUE OR ISSUES NOT BE RESOLVED THROUGH THIS PROCESS, THE APPLICANT MAY APPEAL IN WRITING TO THE CSFM BOARD OF REVIEW. THE WRITTEN APPEAL, SIGNED BY THE APPLICANT, MUST BE RECEIVED AT LEAST 60 DAYS BEFORE THE DATE OF THE REQUESTED EXAMINATION DATE. THE APPLICANT IS RESPONSIBLE FOR DEMONSTRATING THAT THE APPEAL SHOULD BE GRANTED. THE BOARD OF REVIEW SHALL REVIEW THE REQUEST AND NOTIFY THE APPLICANT OF ITS DETERMINATION IN A TIMELY MANNER. THE BOARD OF REVIEW'S DECISION SHALL BE FINAL.

METHOD OF PAYMENT

\$ _____ Check or Money Order (*Made payable to STMA Certification Program*).

I authorize STMA to charge my ___ Visa ___ Mastercard ___ Discover ___ American Express

\$ _____ for my CSFM Application Fee.

Card Number Expiration Date

Cardholder Name (as it appears on the card)

Signature Date

Mail Completed Application to: Sports Turf Managers Association
805 New Hampshire, Ste E
Lawrence, KS 66044

PLEASE NOTE: RESUME AND EDUCATIONAL REQUIREMENTS WORKSHEET MUST BE INCLUDED

FOR OFFICE USE ONLY

HEADQUARTERS PROCESSING RECORD

CODE # _____

APPLICATION & FEE RECEIVED: Date _____ Amount _____ Check # _____

RESUME RECEIVED: Date _____

TENURE AS SPORTS TURF MANAGER _____ (years) Verified by _____

EDUCATION LEVEL (from worksheet) _____ Verified by _____

EMPLOYMENT CONFIRMATION: Contact _____

Date _____ Verified by _____

STMA APPROVED: _____

Date _____ Certification Manager _____

REJECTED: _____

Date _____ Certification Manager _____

REFERRED TO BOARD OF REVIEW: _____

Date _____

COMMENTS: _____

DATE SCHEDULED FOR TESTING: _____

TEST LOCATION: _____

CONTACT: _____ **PHONE #:** _____

TEST RESULTS:

Section 1: _____ PASSED _____ FAILED _____
Date _____

Section 2: _____ PASSED _____ FAILED _____
Date _____

Section 3: _____ PASSED _____ FAILED _____
Date _____

Section 4: _____ PASSED _____ FAILED _____
Date _____

DATE CERTIFIED: _____