CREDENTIAL VERIFICATION REQUEST

Requestor Information

Name _____

Company name _____

Address _____

Email _____

Phone _____ Fax _____

Requestor signature _____ Date _____

Certified Individual's Information

Full name _____

Certification(s) earned (check all that apply): ☐ CPIM ☐ CFPIM ☐ CIRM ☐ CSCP

APICS ID number _____

Address _____

Telephone number _____

Company name (if applicable) _____

I hereby authorize APICS to furnish the Requestor with full information on the status of my APICS certification credentials indicated above for a period of one year from the date noted on the signature line below.

Print name _____

Signature _____ Date _____

Complete and sign this form and fax it to APICS at 773-639-3000, email to certification@apics.org or mail it to:
APICS
Attn: Certification Operations
8430 West Bryn Mawr Ave., Ste. 1000, Chicago, IL 60631
APICS will respond within one week of receipt.