

Fitness & Wellness Standards — Full Guide

Complete criterion-by-criterion guidance: worked examples, first steps, common mistakes, implementation plans, and Monitor verification methods for all 51 criteria.

9 standards · 51 criteria · Version 4.0

ASF STANDARDS · FITNESS & WELLNESS · STANDARD 1

Standard 1 — Pre-Participation Screening & Risk Assessment

5 criteria · 3 non-negotiable · 2 core · Version 3.0

CRITERIA IN THIS STANDARD

- 1.1 — Every New Member Completes a Validated Pre-Participation Screening Before Starting
- 1.2 — A Positive Screening Result Leads to Genuine Medical Clearance, Not Waived Through
- 1.3 — Screening Is Repeated When a Member's Health Status Genuinely Changes
- 1.4 — Risk Stratification Reflects Real, Evidence-Based Criteria
- 1.5 — Screening Results Genuinely Inform the Individual Exercise Program

1.1 Every New Member Completes a Validated Pre-Participation Screening Before Starting

NON-NEGOTIABLE

Every new member completes a validated pre-participation health screening — covering current activity level, signs or symptoms of disease, and desired exercise intensity — before beginning any exercise program, not after, and not skipped because the member seems visibly fit or healthy.

In plain terms: Every new member fills in a validated health screening questionnaire before their first workout — current activity, symptoms, conditions — not a tick box saying 'I am fit to exercise.'

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Sudden cardiac death during exercise happens to people who did not know they were at risk. Chest pain dismissed as indigestion, breathlessness attributed to being unfit, a family history nobody asked about. A validated pre-participation screen — PAR-Q+, the ACSM algorithm, or a national equivalent — asks the questions that identify risk. It takes five minutes. A facility that lets members start without it, or uses a home-made form that misses the key questions, has chosen not to know who might collapse on its floor.

WHAT GOOD LOOKS LIKE

- Every new member completes a genuine, validated screening tool.
- The tool genuinely covers all three key risk factors.
- Screening is completed before, not after, the first exercise session.

COMMON FAILURE MODES

- Screening is skipped or informal, based on how the member appears.
- The tool covers only some risk factors, missing others.
- Members begin exercising before screening is genuinely completed.

WORKED EXAMPLE

IN PRACTICE

A 1,500-member fitness centre using a one-line waiver as its only screening.

BEFORE

New members ticked 'I confirm I am fit to exercise' on the membership form. No health questions. A 52-year-old with undiagnosed heart disease and exertional chest pain he had not mentioned joined and collapsed on a treadmill in his second week.

ACTION	The PAR-Q+ was adopted as mandatory before any exercise: completed at sign-up on a tablet, reviewed by a fitness professional, with the result recorded in the membership system. A positive screen triggers the medical clearance process (1.2). No induction or class access until screening is complete. Screening compliance is audited monthly.
AFTER	The Monitor reviewed 40 recent memberships: all with completed PAR-Q+ before first session; 6 positive screens with clearance documented. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Read your current membership form. Does it ask any health questions?
2. Adopt the PAR-Q+ or a national equivalent.
3. Make it mandatory before any exercise.
4. Record the result in the membership system.

The most common mistake: A tick box that says 'I am fit to exercise' — the member with undiagnosed heart disease will tick it.

SELF-ASSESSMENT QUESTIONS

1. Does every new member complete a validated screening tool before beginning any exercise program? — *A real, validated tool, not an informal conversation or assumption based on appearance.*
Evidence: Pre-participation screening record
2. Does the screening genuinely cover activity level, disease signs and symptoms, and intended exercise intensity? — *Genuine, complete coverage of all three risk factors, not a partial or generic check.*
Evidence: N/A — tested directly
3. Is screening completed before the member's first exercise session, not retroactively after they've already started? — *Real, advance completion, not a formality completed after participation has already begun.*
Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Screening happens for structured classes but not consistently for members using equipment independently.** — Real cardiovascular risk during exercise doesn't depend on whether the activity is instructor-led.
- **The screening tool is used but staff don't consistently review responses before the member starts.** — A completed form that isn't genuinely reviewed provides no real protective value.
- **Screening is thorough for new memberships but not repeated for guests or drop-in visitors.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current screening practice for genuine, validated tool use and timing.
Week 2	Adopt or strengthen a validated pre-participation screening tool.
Week 3	Establish a process ensuring screening is genuinely completed before first participation.
Ongoing	Extend screening consistently to guests and drop-in visitors, not only new members.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Screening record review	Reviews records for a sample of new members to confirm genuine, validated pre-participation screening.
DOCUMENT	Tool completeness review	Reviews the actual screening tool for genuine coverage of activity level, symptoms, and intensity.
ASK	Timing interview	Asks staff to confirm screening timing relative to a new member's first exercise session.

SUPERVISOR TIPS

- **Ask to see the actual screening tool used and confirm it's a real, validated instrument.** — A specific, real tool reveals genuine practice, not an assumption of adequacy.

- **Ask a recent guest or drop-in visitor whether they completed screening before exercising.** — This reveals whether the practice genuinely extends beyond formal members.

EVIDENCE BASE

[1] The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) is established as the international standard for pre-participation risk stratification and screening, with evidence-based preparticipation health screening models stratifying risk based on current physical activity level, presence of disease signs or symptoms, and desired exercise intensity.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

1.2 A Positive Screening Result Leads to Genuine Medical Clearance, Not Waived Through

NON-NEGOTIABLE

When a pre-participation screening identifies a genuine risk indicator, the member is genuinely required to obtain medical clearance before beginning exercise — not permitted to proceed anyway because they're eager to start, or because staff feel the risk seems unlikely to matter.

In plain terms: When the screening finds a risk — chest pain, a heart condition, uncontrolled diabetes — the member gets medical clearance from a doctor before starting, and the facility does not waive it because the member is keen.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

The screen has done its job: it found the risk. Now the facility must act on it. Medical clearance means the member's doctor has said, in writing, that exercise is appropriate and with what limits. It is not a formality to be waived when the member says 'I'll be careful' or the

sales target is close. The clearance is filed; the limits go into the programme (1.5); the member does not exercise until it is in hand. A positive screen waived through is a risk the facility knew about and ignored.

WHAT GOOD LOOKS LIKE

- A positive screening result genuinely, consistently requires medical clearance.
- The requirement is enforced consistently, without informal exceptions.
- Clearance documentation is genuinely verified before participation.

COMMON FAILURE MODES

- Members with a positive screening are permitted to exercise without clearance.
- Enforcement varies based on staff judgement or member pressure.
- Clearance is requested but never actually verified before participation begins.

WORKED EXAMPLE

IN PRACTICE

A 1,200-member fitness centre with screening (1.1) in place but inconsistent follow-through.

BEFORE

Positive screens were noted. Members were 'advised to see a doctor' and allowed to start. Nobody checked. The Coordinator found 30 positive screens in six months with no clearance on file; all members were exercising.

ACTION

The rule was written: any positive screen → no exercise until written medical clearance is on file; a standard clearance form for the doctor specifying any limits; membership fees frozen until clearance; sales staff cannot override. Clearances are logged; any limits are transferred to the member's programme. A monthly audit checks positive screens against clearances.

AFTER

The Monitor reviewed 20 positive screens: all with clearance on file before first exercise; limits recorded in programmes. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull every positive screen from the last six months. How many have a clearance?
2. Write the rule: positive screen → no exercise until clearance.
3. Create a clearance form for doctors.
4. Remove the sales override.

The most common mistake: Advising the member to see a doctor and letting them start anyway.

SELF-ASSESSMENT QUESTIONS

1. Does a positive screening result genuinely require medical clearance before the member begins exercising? — *A real, enforced requirement, not a recommendation the member can simply decline.*

Evidence: Medical clearance requirement documentation

2. Is this requirement consistently enforced, not waived based on staff judgement or member preference? — *Genuine, consistent enforcement, not exceptions made informally.*

Evidence: N/A — tested directly

3. Is clearance documentation genuinely verified before the member is permitted to begin, not just requested? — *Real, confirmed documentation, not an assumption clearance was obtained.*

Evidence: Clearance verification record

COMMON REASONS FOR A PARTIAL ANSWER

- **The requirement is enforced for new members but less consistently for existing members whose status changes.** — A new risk indicator carries the same real significance regardless of how long someone has been a member.
- **Clearance is requested but the specific timeframe for obtaining it before returning isn't clearly enforced.** — An open-ended expectation is less reliable than a specific, enforced timeframe.
- **Documentation is verified for in-person clearance but less consistently for members who provide it remotely.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for genuine, consistent enforcement of medical clearance requirements.
Week 2	Establish a clear, defined process requiring and verifying clearance before participation.
Week 3	Train staff on consistent enforcement without informal exceptions.
Ongoing	Audit clearance requirement enforcement for members with positive screening results.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Clearance requirement review	Reviews whether a positive screening genuinely and consistently triggers a medical clearance requirement.
OBSERVE	Enforcement observation	Observes or reviews records for consistent enforcement, not informal exceptions.
DOCUMENT	Clearance verification review	Reviews whether clearance documentation is genuinely verified before participation begins.

SUPERVISOR TIPS

- **Ask for a real, recent example of a positive screening result and what happened next.** — A real, traced example reveals whether the requirement is genuinely enforced, not just stated as policy.
- **Ask staff what they would do if a member with a pending clearance requirement insisted on starting anyway.** — A specific, confident answer reveals genuine enforcement practice.

EVIDENCE BASE

[2] A single positive response on validated pre-participation screening tools is established as sufficient to warrant a recommendation for medical evaluation before exercise participation begins.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

1.3 Screening Is Repeated When a Member's Health Status Genuinely Changes

NON-NEGOTIABLE

Pre-participation screening is genuinely repeated when a member's health status changes in a way that could affect exercise risk — not performed once at initial sign-up and treated as valid indefinitely regardless of what happens afterward.

In plain terms: If a member's health changes — a new diagnosis, a heart event, pregnancy, an injury — they are re-screened; and members are told to report changes.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

The member screened clear two years ago has since had a heart attack, been diagnosed with diabetes, or become pregnant. The original screen is now wrong. The facility cannot know unless members are told to report changes and are re-screened when they do — and unless there is a periodic re-screen (annually) to catch what was not reported. A change in health is a change in risk; the programme must change with it.

WHAT GOOD LOOKS LIKE

- A real, known process exists for members to report health status changes.
- A reported change genuinely triggers active rescreening.
- Screening is periodically refreshed for long-term members, not reliant solely on self-report.

COMMON FAILURE MODES

- No specific process exists for reporting health status changes.
- Reported changes are noted but don't trigger genuine rescreening.
- Screening is never refreshed after initial sign-up, regardless of membership duration.

WORKED EXAMPLE

IN PRACTICE

A 1,400-member fitness centre that screened at joining only.

BEFORE	Members were screened once. No re-screening. A long-standing member had a cardiac event, was discharged with exercise restrictions, and returned to his previous high-intensity programme because nobody knew.
ACTION	Members are asked at joining to report any health change (a list of examples on a card and in the app) and a 'health update' button was added to the app. Reported changes trigger re-screening and, if positive, clearance (1.2). All members are re-screened annually at renewal. Trainers are told to ask about health changes at every programme review.
AFTER	The Monitor reviewed the health update log (35 reports in six months, all re-screened), the annual re-screening records, and programme review notes with health questions documented. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Tell every member to report health changes — a card and an app button.
2. Re-screen anyone who reports.
3. Re-screen everyone annually at renewal.
4. Ask at every programme review.

The most common mistake: A screening from the day the member joined, treated as permanent.

SELF-ASSESSMENT QUESTIONS

1. Is there a specific process for members to report a genuine health status change after initial screening? — *A real, known process, not an assumption members will volunteer this information unprompted.*

Evidence: Health status change reporting process

2. Does a reported change genuinely trigger rescreening, not simply get noted without further action? — *Real, active rescreening, not passive documentation of a reported change.*

Evidence: Rescreening trigger record

3. Is screening periodically refreshed even without a specifically reported change, for long-term members? — *Genuine, periodic reassessment, not reliance solely on members proactively reporting changes.*

Evidence: Periodic rescreening schedule

COMMON REASONS FOR A PARTIAL ANSWER

- **A reporting process exists but isn't proactively communicated to members after their initial sign-up.** — A process members don't know about after their first visit provides limited real protective value.
- **Rescreening happens for reported cardiac symptoms but less consistently for other relevant changes.** — Multiple types of health change can genuinely affect exercise risk, not cardiac symptoms alone.
- **Periodic refresh happens but the interval is long enough that meaningful changes could go uncaptured.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for genuine rescreening versus one-time initial assessment.
Week 2	Establish and communicate a clear process for members to report health status changes.
Week 3	Build a periodic rescreening schedule for long-term members.
Ongoing	Confirm reported changes genuinely trigger active rescreening.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Reporting process review	Reviews the specific process available for members to report a health status change.

Method	What	Detail
DOCUMENT	Rescreening trigger review	Reviews whether a reported change genuinely triggers active rescreening.
DOCUMENT	Periodic schedule review	Reviews whether screening is periodically refreshed for long-term members.

SUPERVISOR TIPS

- **Ask a long-term member whether they've ever been asked to update their health screening.** — This tests whether periodic refresh is genuine practice, not a one-time formality.
- **Ask staff how a member would actually report a new health concern.** — A specific, confident answer reveals a genuine, known process.

EVIDENCE BASE

[3] Preparticipation health screening and risk stratification is established as an ongoing process responsive to genuine changes in health status, distinct from a single, one-time assessment treated as valid indefinitely.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

1.4 Risk Stratification Reflects Real, Evidence-Based Criteria CORE

Risk stratification following screening genuinely follows evidence-based criteria — current activity level, disease signs and symptoms, desired exercise intensity — not informal staff judgement about who seems likely to be at risk.

In plain terms: After screening, members are placed in risk categories using recognised evidence-based criteria — activity level, symptoms, disease — not a trainer's impression.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

Risk stratification decides how much supervision and what intensity a member starts with. The ACSM algorithm — current activity level, known cardiovascular, metabolic, or renal disease, signs or symptoms — is the evidence base. A trainer's impression ('looks fit') is not. Consistent stratification means every member is classified the same way, the classification is recorded, and it determines what happens next: low risk starts normally; moderate risk starts at lower intensity with supervision; high risk requires clearance. Without it, the same member gets a different answer from different trainers.

WHAT GOOD LOOKS LIKE

- Risk stratification genuinely follows the evidence-based, structured model.
- Staff are specifically trained on the evidence-based criteria.
- Stratification is applied consistently across all staff conducting it.

COMMON FAILURE MODES

- Stratification relies on informal staff judgement, not structured criteria.
- No specific training exists beyond general fitness knowledge.
- Stratification results vary depending on which staff member conducts it.

WORKED EXAMPLE

IN PRACTICE

A 1,300-member fitness centre where trainers judged member risk by eye.

BEFORE

No stratification criteria. Trainers classified members by appearance and confidence. A sedentary 58-year-old with a family history of heart disease was started on high-intensity intervals because he 'seemed motivated.'

ACTION

The ACSM risk stratification algorithm was adopted. Every screened member is classified (low/moderate/high) by a trained fitness professional using the criteria, recorded in the

system. The classification sets the starting protocol: intensity ceiling, supervision level, clearance requirement. Trainers completed a half-day on the algorithm. A monthly audit checks consistency.

AFTER

The Monitor reviewed 40 member records with documented stratification and matching starting protocols; audit showed 96% consistency between assessors. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Adopt the ACSM (or national) stratification criteria.
2. Train every fitness professional on it.
3. Record the classification for every member.
4. Link classification to starting protocol.

The most common mistake: Judging risk by how fit the member looks — the sedentary smoker with a family history may look fine.

SELF-ASSESSMENT QUESTIONS

1. Does risk stratification genuinely follow the evidence-based model, not informal staff judgement? — *A real, structured process using established criteria, not subjective impression.*

Evidence: Risk stratification protocol documentation

2. Are staff conducting stratification genuinely trained on the evidence-based criteria, not relying on general fitness knowledge alone? — *Specific, documented training, not assumed competence.*

Evidence: Staff training record

3. Is stratification consistently applied across different staff members, not varying based on who happens to review it? — *Genuine, consistent application, not results that vary depending on which staff member conducts the review.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The structured model is used for obvious risk cases but informal judgement fills in for ambiguous ones.** — Ambiguous

cases are exactly where structured, evidence-based criteria provide the most real protective value.

- **Training covers the model's basic structure but not the full range of specific risk indicators.** — Genuine competence requires full, specific knowledge of the model's actual criteria.
- **Consistency is generally strong but newer staff apply the model less confidently.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current risk stratification practice for genuine evidence-based structure versus informal judgement.
Week 2	Train all staff specifically on the evidence-based stratification model and its full criteria.
Week 3	Establish consistency checks across staff conducting stratification.
Ongoing	Refresh staff training periodically, particularly for newer team members.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Stratification protocol review	Reviews the actual risk stratification process for genuine adherence to evidence-based criteria.
DOCUMENT	Staff training review	Reviews training records confirming staff are specifically trained on the evidence-based model.
OBSERVE	Consistency observation	Observes or reviews records for consistent stratification across different staff members.

SUPERVISOR TIPS

- **Ask a staff member to walk through the actual stratification criteria for a specific, real case.** — A specific, confident answer reveals genuine, structured competence, not general fitness knowledge.
- **Ask how stratification would differ between a newer and a more experienced staff member.** — This reveals whether consistency

genuinely holds across the whole team.

EVIDENCE BASE

[4] Established evidence-based preparticipation health screening models use a structured decision process based on current physical activity level, presence of disease signs or symptoms, and desired exercise intensity, distinct from informal staff assessment of risk.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

1.5

Screening Results Genuinely Inform the Individual Exercise Program

CORE

Pre-participation screening results genuinely, actively inform the member's individual exercise program design — not collected as a compliance formality and then filed without any real connection to the actual program the member follows.

In plain terms: What the screening found actually shapes the member's programme — a heart condition limits intensity, a knee injury changes exercises, a clearance letter's limits are followed.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

The screening identified hypertension. The doctor's clearance said 'avoid heavy isometric loading.' The programme includes maximal deadlifts. The screen and clearance were done and ignored.

Integration means: the programme designer reads the screening and any clearance before writing the programme; every identified condition or limit has a specific programme adaptation; the adaptation is recorded; trainers delivering the programme know it. A screening that does not change the programme was a form-filling exercise.

- Screening results genuinely, demonstrably inform individual program design.
- Staff can explain specific, real connections between findings and program decisions.
- Program individualization is revisited when screening results change.

- Screening is filed without any real connection to actual program design.
- Staff cannot explain how screening findings shaped a specific program.
- Programs remain fixed regardless of any change in screening results.

WORKED EXAMPLE

IN PRACTICE

A 1,500-member fitness centre where screening and programming were done by different people who did not communicate.

BEFORE

Screening results were filed by reception. Programmes were written by trainers from a fitness assessment only. A member cleared 'with a heart rate ceiling of 130' was on a programme with no heart rate monitoring. Another with a documented back injury was prescribed loaded flexion.

ACTION

The programme design process now starts with the screening and clearance: the trainer reviews them, records each condition or limit, and specifies the adaptation in the programme (intensity ceiling, exercise substitutions, monitoring). The programme template has a 'health considerations' section that must be completed. Any trainer delivering the programme reads it. Adaptations are checked at programme review.

AFTER

The Monitor reviewed 30 programmes with health considerations sections matching screening results and clearance limits. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull ten programmes for members with positive screens. Does the programme reflect the finding?
2. Add a mandatory 'health considerations' section to the programme template.
3. Require the trainer to read the screening before writing.
4. Check at programme review.

The most common mistake: Screening filed at reception, programme written in the gym — never meeting.

SELF-ASSESSMENT QUESTIONS

1. Do screening results genuinely, actively inform the member's individual exercise program? — *Real, demonstrated connection between screening findings and actual program design.*

Evidence: Program individualization documentation

2. Can staff explain how a specific screening finding shaped a specific member's actual program? — *A real, specific, traceable connection, not a general assumption that screening is considered.*

Evidence: N/A — tested directly

3. Is program individualization revisited if screening results change, not left fixed from the original assessment? — *Genuine, ongoing responsiveness, not a program based only on the initial screening, never revisited.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Connection is clear for members with an identified risk factor but less clear for those screened as lower risk.** — Even a lower-risk screening result should genuinely inform appropriate program design, not just be filed.
- **Initial program design reflects screening but later program adjustments don't consistently reference it.** — The connection between screening and program design should persist throughout the member's ongoing participation, not only at the start.
- **Staff describe considering screening generally but can't point to a specific, real example.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current program design practice for genuine connection to screening results.
Week 2	Establish a clear process linking screening findings to individual program decisions.
Week 3	Train staff to document and explain this connection for each member.
Ongoing	Revisit program individualization when screening results are updated.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Individualization connection review	Reviews evidence connecting screening results to actual individual program design.
ASK	Staff connection interview	Asks staff to explain how a specific screening finding shaped a specific member's program.
DOCUMENT	Program update review	Reviews whether program individualization is revisited following a screening update.

SUPERVISOR TIPS

- **Ask staff to trace a specific member's screening result through to their actual program.** — A real, traceable example reveals genuine connection, not policy language alone.
- **Ask how a program changed after a member's screening results were updated.** — A specific, real example reveals ongoing responsiveness, not a fixed initial assessment.

EVIDENCE BASE

[5] Preparticipation screening results are established as intended to directly inform individualized exercise program design and intensity, distinct from screening treated as an administrative record disconnected from actual program development.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

[← Fitness & Wellness Standards — all standards](#)

[Self-assess against these criteria →](#)

[Standard 2 — Exercise Supervision & Instructor Qualification →](#)

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ASF STANDARDS · FITNESS & WELLNESS · STANDARD 2

Standard 2 — Exercise Supervision & Instructor Qualification

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

2.1 — Every Instructor Holds a Genuine, Accredited Certification

2.2 — CPR and AED Certification Is Current for Every Instructor, Verified Not Assumed

2.3 — Scope of Practice Is Respected, Not Exceeded

2.4 — A Class or Session Is Never Run Without a Qualified Instructor Actually Present

2.5 — Instructor Credentials Are Verified Before Hire and Periodically Reconfirmed

2.1 Every Instructor Holds a Genuine, Accredited Certification

NON-NEGOTIABLE

Every staff member directing exercise — personal trainer, group instructor, specialist coach — holds a genuine, accredited certification from a recognised body, not an informal qualification, a brief in-house orientation, or no formal credential at all.

In plain terms: Every trainer, instructor, and coach holds a real certification from an accredited body — checked with the body, not just a certificate on the wall.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Anyone can call themselves a personal trainer. Certification from an accredited body (NCCA-accredited in the US, CIMSPA in the UK, EREPS in Europe, or national equivalents) means the person has been examined on exercise science, programming, and safety. A weekend course from an unaccredited provider does not. Unqualified instruction injures members — poor technique, inappropriate loads, missed warning signs. The facility must know which certifications it accepts, verify each with the certifying body, and file the evidence.

WHAT GOOD LOOKS LIKE

- Every instructor holds a genuine, accredited certification.
- Certifications are genuinely verifiable against the certifying body.
- Certification specifically matches the activity each instructor directs.

COMMON FAILURE MODES

- Instructors rely on informal or in-house qualification alone.
- Claimed certifications cannot be genuinely verified.
- A general certification is stretched to cover specialty activities it doesn't actually address.

WORKED EXAMPLE

IN PRACTICE

A 1,200-member fitness centre with 15 instructors of varied backgrounds.

BEFORE

Instructors were hired on experience and a certificate. Nobody checked the certificate or the certifying body. Three instructors held certifications from unaccredited online providers; one had a certificate that could not be traced to any body.

ACTION	A list of accepted accredited certifications was adopted from the national register. Every instructor's certification was verified directly with the certifying body and filed with the verification date. Instructors without accepted certification were given six months to obtain one or moved to non-instructional roles. New hires require verified accredited certification before instructing.
AFTER	The Monitor reviewed 15 instructor files with verified accredited certifications. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every instructor and their certification.
2. Check each certifying body against the national accredited list.
3. Verify each certificate with the body.
4. Set a deadline for anyone without accepted certification.

The most common mistake: Accepting a certificate without checking whether the body that issued it is accredited.

SELF-ASSESSMENT QUESTIONS

1. Does every staff member directing exercise hold a genuine, accredited certification, not an informal or in-house qualification? — *A real, externally accredited certification, not internal training alone.*
Evidence: Instructor certification record

2. Is the specific certifying body and credential genuinely verifiable, not just claimed? — *A real, checkable credential, not an assumed or unverifiable qualification.*
Evidence: N/A — tested directly

3. Does the certification genuinely match the specific activity the instructor directs — a Pilates certification for Pilates, not a general credential applied broadly? — *Specific, matched qualification, not a general certification stretched to cover unrelated specialties.*
Evidence: Certification-activity match documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Certification is verified for full-time staff but less consistently for part-time or guest instructors.** — Every instructor directing

exercise carries the same real responsibility, regardless of employment status.

- **Certification is genuine but hasn't been specifically checked for continued active status.** — Some certifications expire or lapse, and continued active status deserves the same verification as initial credentialing.
- **Certification is verified for the primary activity but not for supplementary services the instructor also provides.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current instructor qualifications for genuine, accredited certification versus informal training.
Week 2	Verify all claimed certifications against the actual certifying bodies.
Week 3	Confirm certification-activity matching for every instructor and specialty offered.
Ongoing	Extend verification consistently to part-time and guest instructors.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Certification record review	Reviews certification records for every instructor for genuine, accredited credentials.
DOCUMENT	Verifiability check	Verifies a sample of claimed certifications against the actual certifying body's records.
DOCUMENT	Activity match review	Reviews whether each instructor's certification genuinely matches the specific activity they direct.

SUPERVISOR TIPS

- **Ask to see the actual certification document for a specific instructor, not a general assurance of qualification.** — A specific, real document is the evidence of genuine credentialing, not an assumption.
- **Ask about qualification for a specialty class specifically, not just general fitness instruction.** — This reveals whether

certification genuinely matches every activity offered, not just the most common one.

EVIDENCE BASE

[6] The National Commission for Certifying Agencies (NCCA), established in 1989 as an independent accreditation body, requires certification programs to demonstrate compliance with 23 specific accreditation standards, establishing NCCA accreditation as the recognised benchmark for genuine personal trainer and group exercise instructor qualification.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

2.2 CPR and AED Certification Is Current for Every Instructor, Verified Not Assumed

NON-NEGOTIABLE

Every instructor directing exercise holds a current, genuinely verified CPR and AED certification — not a certification that has quietly lapsed, or one assumed current without actually checking the expiration date.

In plain terms: Every instructor's CPR and AED certification is current — checked with the training provider, expiry tracked — not assumed from a card that may have expired.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

The instructor standing next to a member who collapses must know CPR and how to use the AED, now, without hesitation. CPR skills decay within months; certifications expire in one to two years; a card from four years ago is a card. The facility must verify each instructor's certification with the provider, record the expiry, remind before expiry, and remove from instruction anyone who lapses. Practice between certifications — a quarterly drill (3.4) — keeps the skill alive.

WHAT GOOD LOOKS LIKE

- Every instructor holds a genuinely current CPR/AED certification.
- Currency is actively, specifically verified, not assumed.
- A proactive process identifies and addresses certifications approaching expiration.

COMMON FAILURE MODES

- Some instructors' certifications have lapsed without being noticed.
- Currency is assumed from initial hire, never actively reverified.
- No process exists to catch an approaching expiration before it lapses.

WORKED EXAMPLE

IN PRACTICE

A 1,400-member fitness centre that required CPR certification at hire.

BEFORE	CPR cards were copied at hire. No expiry tracking. Of 18 instructors, 11 had expired certifications; two had never actually completed the course their card claimed.
ACTION	CPR/AED certification was verified with each provider and expiry recorded. A 60-day reminder system was set. Instructors with expired certification were removed from the rota until recertified (the facility funded a group course). New hires require verified current certification. Quarterly drills supplement.
AFTER	The Monitor reviewed 18 instructor files with verified current CPR/AED certifications and the expiry tracker (none expired). Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every instructor's CPR/AED expiry date. Any expired?
2. Verify each with the training provider.
3. Set 60-day reminders.
4. Remove lapsed instructors from the rota until recertified.

The most common mistake: A CPR card copied at hire and never looked at again.

SELF-ASSESSMENT QUESTIONS

1. Does every instructor hold a genuinely current CPR and AED certification? — *Real, current certification, not one assumed valid without checking the actual expiration.*

Evidence: CPR/AED certification record

2. Is certification currency actively, specifically verified, not just assumed from initial hiring? — *Real, active verification, not an assumption certification obtained at hire remains valid indefinitely.*

Evidence: Currency verification process

3. Is there a specific process for identifying and addressing a certification that's about to lapse? — *A real, proactive process, not discovering a lapse only after it's already occurred.*

Evidence: Lapse prevention process

COMMON REASONS FOR A PARTIAL ANSWER

- **Currency is checked for staff CPR/AED but not for guest or contracted instructors.** — Every instructor directing exercise carries the same real emergency response responsibility.
- **A tracking system exists but isn't consistently reviewed on a regular schedule.** — A tracking system that isn't actively reviewed provides limited real protective value.
- **Expiration is caught eventually but not far enough in advance to arrange renewal without a gap.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current CPR/AED certification status for all instructors, including guest and contracted staff.
Week 2	Establish a systematic tracking and verification process for certification currency.
Week 3	Build proactive advance notice for approaching expirations.
Ongoing	Audit certification currency on a regular schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Certification currency review	Reviews CPR/AED certification records for every instructor to confirm genuinely current status.
DOCUMENT	Verification process review	Reviews the process for actively verifying certification currency, not assuming it from hire date.
DOCUMENT	Lapse prevention review	Reviews the proactive process for identifying certifications approaching expiration.

SUPERVISOR TIPS

- **Ask to see the actual, current CPR/AED certification for a specific instructor.** — A specific, real, current document reveals genuine verification, not an assumption.
- **Ask how the facility would know if a certification were about to expire.** — A specific, confident answer reveals a genuine, proactive process.

EVIDENCE BASE

[7] Current CPR/AED credentialing is established as a baseline eligibility requirement for accredited fitness certification, reflecting the genuine, specific relevance of cardiac emergency response competence to directing exercise.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

2.3 Scope of Practice Is Respected, Not Exceeded

NON-NEGOTIABLE

Instructors genuinely stay within their actual scope of practice — providing exercise guidance and general fitness nutrition information, not individualized medical or clinical nutrition advice that belongs to a licensed dietitian or physician.

In plain terms: Trainers give exercise guidance — not diagnoses, not treatment plans, not dietary prescriptions for medical conditions, not physiotherapy — and know where their role ends.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Full	Full

WHY THIS MATTERS

A trainer who tells a member their knee pain is 'just tightness' and prescribes stretches has diagnosed and treated without a licence. A trainer who designs a diet for a diabetic member has practised dietetics. A trainer who 'rehab's a shoulder has practised physiotherapy. Scope of practice protects members from unqualified advice and trainers from liability. It must be defined in writing (from the certifying body's scope statement), trained, and enforced: when a member's need is medical, dietary, or rehabilitative, the trainer refers.

WHAT GOOD LOOKS LIKE

- Instructors genuinely, consistently stay within their actual scope of practice.
- Instructors are specifically trained on the real boundary requiring referral.
- A clear referral pathway exists and is used when scope is exceeded.

COMMON FAILURE MODES

- Instructors provide advice that exceeds their actual certified competence.
- No specific training addresses scope of practice boundaries.
- No referral pathway exists for needs beyond instructor scope.

WORKED EXAMPLE

IN PRACTICE

A 1,300-member fitness centre with trainers routinely advising on injuries and diets.

BEFORE

Trainers diagnosed injuries, prescribed rehabilitation, and designed diets for members with medical conditions. A member with an undiagnosed stress fracture was told to 'train through it' and suffered a complete fracture. A

	diabetic member's blood glucose became unstable on a trainer-designed diet.
ACTION	A scope of practice policy was written from the certifying bodies' scope statements: trainers provide exercise programming and general healthy-eating guidance; they do not diagnose, treat injuries, or prescribe diets for medical conditions; any pain, injury, or medical dietary need is referred (a referral list of local physiotherapists, dietitians, and GPs). Trainers completed a scope session with scenarios. Referrals are logged.
AFTER	The Monitor reviewed the policy, training records, and the referral log (40 referrals in six months). Interviewed two trainers who described their scope limits accurately. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask three trainers what they would tell a member with knee pain.
2. Write a scope policy from your certifying bodies' statements.
3. Build a referral list.
4. Train with scenarios.

The most common mistake: Trainers 'helping' with injuries and diets because they want to help — help outside scope harms.

SELF-ASSESSMENT QUESTIONS

1. Do instructors genuinely stay within their actual certified scope of practice? — *Real, respected boundaries, not advice that quietly exceeds what the certification actually covers.*

Evidence: N/A — tested directly

2. Are instructors specifically trained on the boundary between general fitness guidance and clinical advice requiring referral? — *Specific, documented training on this real boundary, not an assumption instructors will intuit it.*

Evidence: Scope of practice training record

3. Is there a clear referral pathway when a member's need genuinely exceeds an instructor's scope? — A real, known referral pathway, not the instructor attempting to address something beyond their actual competence.

Evidence: Referral pathway documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Scope is respected for nutrition specifically but less clearly defined for other health-adjacent topics.** — Every area where an instructor's competence has real limits deserves the same clear boundary.
- **Instructors understand the general principle but aren't confident identifying specific situations requiring referral.** — General awareness needs to translate into genuine, practical recognition of real boundary situations.
- **A referral pathway exists but isn't consistently used when a genuine scope boundary is reached.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for genuine scope of practice adherence.
Week 2	Train instructors specifically on scope boundaries and recognising when referral is needed.
Week 3	Establish a clear, known referral pathway for needs beyond instructor scope.
Ongoing	Audit instructor guidance for continued scope adherence.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Scope observation	Observes instructor-member interactions for genuine adherence to scope of practice.
DOCUMENT	Training review	Reviews training records confirming instructors are specifically trained on scope boundaries.

Method	What	Detail
DOCUMENT	Referral pathway review	Reviews the referral pathway available when a member's need exceeds instructor scope.

SUPERVISOR TIPS

- **Ask an instructor to describe where their scope of practice ends and referral begins.** — A specific, confident answer reveals genuine understanding, not assumed awareness.
- **Ask for a real, recent example of a member referred elsewhere for a need beyond instructor scope.** — A real example reveals whether the referral pathway is genuinely used, not just theoretically available.

EVIDENCE BASE

[8] Fitness nutrition coaching certifications explicitly establish a scope of practice that remains limited compared to that of a registered and licensed dietitian, distinguishing genuine fitness-related guidance from clinical nutrition or medical advice.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

2.4 A Class or Session Is Never Run Without a Qualified Instructor Actually Present

NON-NEGOTIABLE

Every group class and supervised session has a genuinely qualified instructor actually present and actively supervising for its full duration — not a class run unsupervised, or supervision handed off to an unqualified staff member when the certified instructor is unavailable.

In plain terms: No class or supervised session runs without a qualified instructor actually in the room, watching — not a video, not an instructor covering two rooms, not a receptionist.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A group class with no instructor is a room of people doing potentially dangerous things unsupervised. An instructor 'covering' two classes is supervising neither. A video class with no one present has no one to notice a member's chest pain or bad form. Supervised means a qualified instructor is present, attentive, and able to intervene — for the whole session. If the instructor is absent, the class is cancelled. The rota is checked; classes are not run on hope.

WHAT GOOD LOOKS LIKE

- A qualified instructor is genuinely present for the full duration of every session.
- A specific, defined process handles instructor unavailability without compromising supervision.
- Supervision is genuinely active and attentive throughout.

COMMON FAILURE MODES

- Classes sometimes run without a qualified instructor actually present.
- No defined process exists for instructor unavailability, risking unsupervised sessions.
- Supervision is nominal, with attention genuinely elsewhere during the class.

WORKED EXAMPLE

IN PRACTICE

A 1,500-member fitness centre with a busy class timetable and frequent instructor absences.

BEFORE

When instructors were absent, classes ran as 'follow the video' with a receptionist checking in occasionally, or one instructor ran two adjacent classes. A member collapsed in an unsupervised class and was not found for several minutes.

ACTION

A rule was written: no class without a qualified instructor present throughout; absent instructor → class cancelled with members notified, or a qualified cover found; one instructor per class, no

exceptions. A cover pool of qualified instructors was established. The rota is checked daily by the fitness manager. Members are told the rule.

AFTER

The Monitor reviewed the rule, the cover pool, the daily rota check log, and 12 cancellations in six months for instructor absence. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check last month's timetable: did any class run without a qualified instructor present?
2. Write the rule: no instructor, no class.
3. Build a cover pool.
4. Check the rota daily.

The most common mistake: Running the class 'to the video' rather than cancelling — the members would rather be told than be unsupervised.

SELF-ASSESSMENT QUESTIONS

1. Is a genuinely qualified instructor actually present for the full duration of every class or supervised session? — *Real, continuous presence, not supervision that lapses partway through.*

Evidence: Class supervision record

2. Is there a specific, defined process for what happens if the scheduled instructor becomes unavailable? — *A real, defined backup process, not the class running unsupervised or handed to an unqualified staff member.*

Evidence: Instructor unavailability protocol

3. Is supervision genuinely active — attentive, engaged — not merely nominal presence in the room? — *Real, active supervision, not passive presence while attention is elsewhere.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Supervision is reliable for scheduled classes but less consistent for open equipment areas.** — Genuine supervision matters across all supervised areas, not scheduled classes alone.

- **A backup process exists but relies on whichever staff member happens to be available, not a specifically qualified alternate.** — A genuine backup needs to maintain the same qualification standard as the original supervision.
- **Presence is consistent but attention is sometimes divided with administrative tasks during the session.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current supervision practice for genuine, continuous qualified presence.
Week 2	Establish a specific, qualified backup process for instructor unavailability.
Week 3	Address any administrative task overlap that divides attention during active supervision.
Ongoing	Audit supervision presence and attentiveness periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Supervision presence observation	Observes an actual class or session for genuine, continuous qualified instructor presence.
DOCUMENT	Unavailability protocol review	Reviews the specific process for handling scheduled instructor unavailability.
OBSERVE	Active supervision observation	Observes whether supervision is genuinely active and attentive, not merely nominal.

SUPERVISOR TIPS

- **Observe an actual class or session directly for genuine, continuous qualified presence.** — Direct observation reveals whether supervision is genuine, not assumed from the schedule.
- **Ask what happens if the scheduled instructor calls in unavailable shortly before a class.** — A specific, confident answer reveals a genuine backup process, not improvisation.

EVIDENCE BASE

[9] Professionally qualified exercise staff, possessing academic training, practical and clinical knowledge, skills, and abilities commensurate with defined credentials, is established as a foundational requirement for safe exercise facility operation, distinct from unsupervised or informally supervised activity.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

2.5

Instructor Credentials Are Verified Before Hire and Periodically Reconfirmed

CORE

Instructor credentials are genuinely verified before hire — confirmed directly with the certifying body, not accepted on the instructor's own representation alone — and periodically reconfirmed thereafter, not verified once and assumed to remain accurate indefinitely.

In plain terms: Instructor certifications are checked with the certifying body before hire and re-checked periodically — a certificate is evidence of a certificate, not of a qualification.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

This combines the verification principle of 2.1 with the periodic re-check of 2.2 for all credentials, not just CPR. Certifications can be forged, lapsed, or revoked. The certifying body can confirm current status. Verification at hire and every two years, recorded, with expiry tracked, is the standard. A facility that verifies once, or never, does not know whether its instructors are qualified today.

WHAT GOOD LOOKS LIKE

- Credentials are genuinely verified directly with

COMMON FAILURE MODES

- Credentials are accepted on the applicant's own

certifying bodies before hire.

- Verification is periodically reconfirmed, not treated as permanent.
- A real, defined response follows if reconfirmation reveals an issue.

representation without direct verification.

- Verification happens once at hire and is never reconfirmed.
- No defined response exists if a credential issue is later discovered.

WORKED EXAMPLE

IN PRACTICE

A 1,200-member fitness centre that checked certificates at hire only.

BEFORE	Certificates were copied at hire. Two instructors' certifications had lapsed for non-renewal. One instructor's certification had been revoked by the body for misconduct; the facility did not know.
ACTION	Primary verification with each certifying body at hire and every two years; expiry dates tracked with reminders; instructors self-declare any change in status; instructors with lapsed or revoked certification are removed from instruction. A credentials register is maintained by the fitness manager.
AFTER	The Monitor reviewed the credentials register with verification dates for all instructors and the reminder system. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Contact each certifying body and confirm every instructor's current status.
2. Record expiry and set reminders.
3. Re-verify every two years.
4. Require self-declaration of any status change.

The most common mistake: Verifying at hire and never again — the revoked certification is invisible.

SELF-ASSESSMENT QUESTIONS

1. Are instructor credentials genuinely verified directly with the certifying body before hire, not accepted on self-report alone? —

Real, direct verification, not simply trusting what the applicant claims.

Evidence: Pre-hire verification record

2. Is verification periodically reconfirmed after hire, not treated as permanently established? — *Real, periodic reconfirmation, not a one-time check assumed to remain valid indefinitely.*

Evidence: Periodic reconfirmation record

3. Is there a specific process for what happens if reconfirmation reveals a credential has changed or lapsed? — *A real, defined response, not discovery without any resulting action.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Direct verification happens for the primary certification but not for supplementary specialty credentials.** — Every credential relied upon for a specific activity deserves the same genuine verification.
- **Reconfirmation happens but at an interval long enough that a lapse could go uncaught for a meaningful period.** — A genuinely protective interval catches issues before they've mattered for an extended time.
- **A response process exists but hasn't been tested against a real, identified credential issue.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current hiring practice for genuine, direct credential verification.
Week 2	Establish direct verification with certifying bodies for all claimed credentials.
Week 3	Build a periodic reconfirmation schedule with a defined response process.
Ongoing	Reconfirm credentials on the established schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Pre-hire verification review	Reviews evidence of genuine, direct verification with certifying bodies before hire.
DOCUMENT	Periodic reconfirmation review	Reviews whether credentials are genuinely reconfirmed periodically after hire.
ASK	Response process interview	Asks staff what happens if periodic reconfirmation reveals a credential issue.

SUPERVISOR TIPS

- **Ask how the facility would directly verify a specific instructor's claimed certification.** — A specific, confident answer reveals a genuine verification process, not assumed trust.
- **Ask for a real example of periodic reconfirmation catching an actual credential issue.** — A real example, or its honest absence, reveals whether reconfirmation genuinely functions.

EVIDENCE BASE

[10] Genuine verification of claimed certifications directly with accredited certifying bodies, distinct from acceptance of self-reported credentials, is established practice for ensuring instructor qualification is real, not merely claimed.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Fitness & Wellness Standards — all standards**

Self-assess against these criteria →

← **Standard 1 — Pre-Participation Screening & Risk Assessment**

Standard 3 — Emergency Preparedness & Cardiac Event Response →

ASF STANDARDS · FITNESS & WELLNESS · STANDARD 3

Standard 3 — Emergency Preparedness & Cardiac Event Response

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

3.1 — An AED Is Genuinely Within a Two-Minute Round Trip of Every Exercise Area

3.2 — AED Function Is Verified Through Regular, Documented Maintenance Checks

3.3 — Every Staff Member Present Can Actually Use the AED and Perform CPR

3.4 — A Cardiac Event Triggers an Immediate, Practiced Response, Not Improvisation

3.5 — Post-Event Review Genuinely Examines Response Time and Outcome

3.1 An AED Is Genuinely Within a Two-Minute Round Trip of Every Exercise Area

NON-NEGOTIABLE

An automated external defibrillator is genuinely positioned within a two-minute walking round trip of every area where exercise takes place, verified directly by physically walking the actual route, not estimated or assumed from the facility's general layout.

In plain terms: An AED is within a two-minute round trip of every place people exercise — measured by walking it, not by looking at a floor plan.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Survival from cardiac arrest falls by about 10% for every minute without defibrillation. An AED reached in four minutes gives a fair chance; in eight minutes, almost none. 'We have an AED' means nothing if it is at reception on the ground floor and the collapse is in the top-floor studio behind two doors. The two-minute round trip — from the exercise area to the AED and back — must be walked and timed from the furthest point of every exercise area. If it exceeds two minutes, a second AED is needed. Large or multi-floor facilities typically need several.

WHAT GOOD LOOKS LIKE

- An AED is genuinely within a verified two-minute round trip of every exercise area.
- Distance has been physically walked and timed, not just estimated.
- Large or multi-floor facilities have multiple AEDs genuinely covering every area.

COMMON FAILURE MODES

- AED placement exceeds a two-minute round trip from some exercise areas.
- Distance is estimated from a floor plan, never physically verified.
- A single AED serves a large facility, leaving some areas genuinely uncovered.

WORKED EXAMPLE

IN PRACTICE

A 1,800-member fitness centre on three floors with one AED at reception.

BEFORE

The single AED was at reception. The Coordinator timed the round trip from the third-floor studio: 4 minutes 40 seconds including stairs and doors. From the pool: 3 minutes 10 seconds. The facility believed it was covered.

ACTION	Round trips were timed from the furthest point of every exercise area. Two additional AEDs were installed (third floor, pool area). All round trips are now under two minutes. AED locations are marked on signage in every area and on the floor plan at reception. The timing is repeated annually and after any layout change.
AFTER	The Monitor walked and timed the round trip from four locations: all under two minutes. Reviewed the timing records and signage. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Walk from the furthest corner of each exercise area to the AED and back. Time it.
2. Any round trip over two minutes needs another AED.
3. Install and mark them.
4. Re-time annually.

The most common mistake: One AED at reception for a three-floor facility.

SELF-ASSESSMENT QUESTIONS

1. Is an AED genuinely positioned within a two-minute walking round trip of every area where exercise occurs? — *A real, verified distance, not an estimate based on general facility layout.*

Evidence: AED placement verification

2. Has this distance been physically walked and timed, not just measured on a floor plan? — *Real, physical verification, not a theoretical calculation.*

Evidence: N/A — tested directly

3. For a multi-floor or large facility, are multiple AEDs positioned to genuinely meet this standard everywhere, not just near the main entrance? — *Genuine, complete coverage of every exercise area, not concentrated in one convenient location.*

Evidence: Multi-AED coverage documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Coverage is adequate for the main gym floor but not verified for a separate studio or outdoor training area.** — Every genuine exercise area deserves the same real coverage, not only the primary space.
- **The route was walked once at installation but hasn't been reverified after any layout change.** — A layout change can genuinely alter real walking distance, and verification needs to reflect current conditions.
- **Coverage is adequate during normal hours but not reassessed for areas open during reduced staffing.**

IMPLEMENTATION PLAN

When	What
Week 1	Physically walk and time the actual route from every exercise area to the nearest AED.
Week 2	Address any area exceeding the two-minute round trip standard.
Week 3	For larger facilities, position additional AEDs to achieve genuine, complete coverage.
Ongoing	Reverify distances after any facility layout change.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Physical distance verification	Physically walks the route from each exercise area to the nearest AED and times the actual round trip.
DOCUMENT	Placement documentation review	Reviews AED placement records and facility layout for genuine two-minute coverage.
OBSERVE	Multi-area coverage check	Confirms coverage extends to every exercise area in a large or multi-floor facility, not just the primary space.

SUPERVISOR TIPS

- **Physically walk the route from the furthest exercise area to the nearest AED and time it directly.** — Direct, physical verification is

the only real evidence of genuine coverage, not a floor-plan estimate.

- **Ask about coverage for any less obvious exercise area, like an outdoor space or a separate studio.** — This is where coverage gaps most commonly hide.

EVIDENCE BASE

[11] A study of sudden cardiac arrest across 252 sports facilities over 18 years found neurologically intact survival rates of 93 percent in centres with an on-site AED compared with 9 percent in centres without one, with on-site AED presence the only independent predictor of survival in multivariate analysis.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

3.2 **AED Function Is Verified Through Regular, Documented Maintenance Checks**

NON-NEGOTIABLE

The AED's function is genuinely verified through regular, documented checks — battery status, pad expiration, device readiness — not assumed functional because it's present, given most AED models lack built-in connectivity and require active, manual verification.

In plain terms: The AED is checked on a schedule — battery, pads in date, readiness light — and the checks are written down.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

An AED with a dead battery or expired pads is a box on the wall. Batteries last two to five years; pads expire; the self-test indicator must be looked at. A weekly visual check (readiness indicator, pads present, expiry date) and a monthly documented check (battery status, pad

expiry, accessories, cabinet alarm) by a named person, with expiries tracked and replacements ordered ahead, keeps the AED usable. The log is the evidence; a facility without one does not know.

WHAT GOOD LOOKS LIKE

- AED function is genuinely, regularly checked and documented.
- Battery status and pad expiration are specifically, actively verified.
- A real, defined response addresses any identified issue immediately.

COMMON FAILURE MODES

- AED function is assumed adequate simply because the device is present.
- Checks, if they happen, don't specifically verify battery or pad status.
- An identified issue doesn't trigger any specific, resulting response.

WORKED EXAMPLE

IN PRACTICE

A 1,400-member fitness centre with two AEDs and no check schedule.

BEFORE	AEDs were 'looked at sometimes.' One had pads expired 14 months earlier. The other's battery indicator showed low. No log existed.
ACTION	A weekly visual check (readiness light, pads present, seal intact) by the duty manager, logged. A monthly detailed check (battery, pad expiry, accessories, cabinet) by the fitness manager, logged. Expiry dates in a tracker with 90-day reordering. Expired pads and low battery were replaced. A service contract for annual maintenance.
AFTER	The Monitor inspected both AEDs (ready, pads in date), reviewed 12 weeks of logs, and the expiry tracker. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Open each AED cabinet now. Is the readiness light green? Are the pads in date?
2. Start a weekly visual check log.

3. Track pad and battery expiry with 90-day reorder.
4. Name a person responsible.

The most common mistake: An AED nobody has opened since it was installed.

SELF-ASSESSMENT QUESTIONS

1. Is AED function genuinely verified through regular, documented checks, not assumed from presence alone? — *Real, scheduled, documented verification, not an assumption the device works because it's there.*

Evidence: AED maintenance check record

2. Are battery status and pad expiration specifically checked, not just general device presence? — *Specific, genuine verification of these particular components, not a general glance at the device.*

Evidence: N/A — tested directly

3. Is there a specific, immediate process for what happens if a check identifies a problem? — *A real, defined response, not a problem identified without resulting action.*

Evidence: Maintenance issue response process

COMMON REASONS FOR A PARTIAL ANSWER

- **Checks happen but not on a consistently maintained monthly schedule.** — A consistent, regular schedule is what makes verification genuinely reliable, not occasional attention.
- **Battery status is checked but pad expiration dates are less consistently verified.** — Both components need genuine, specific verification for the device to actually function when needed.
- **Checks are documented but the documentation isn't reviewed to confirm checks are actually happening as scheduled.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current AED maintenance practice for genuine, regular, documented checks.
Week 2	Establish a monthly check schedule specifically verifying battery and pad status.

When	What
Week 3	Build a defined, immediate response process for any identified issue.
Ongoing	Confirm checks are genuinely occurring as scheduled through documentation review.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Maintenance check record review	Reviews documented, regular AED maintenance checks for genuine, specific verification.
OBSERVE	Current device check	Physically checks the AED's actual current battery and pad status.
DOCUMENT	Issue response review	Reviews the process for responding to an identified maintenance issue.

SUPERVISOR TIPS

- **Ask to see the actual, current maintenance log and physically check the device's current status.** — A real, current record compared against actual device status reveals genuine verification, not assumed function.
- **Ask what happens specifically if a check reveals an expired pad.** — A specific, confident answer reveals a genuine response process, not an assumption it would be handled.

EVIDENCE BASE

[12] Most AED models lack built-in connectivity to report their own status, establishing regular, manual verification of battery status, pad expiration, and device readiness as necessary practice, distinct from assumed functionality based on presence alone.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

3.3 Every Staff Member Present Can Actually Use the AED and Perform CPR

NON-NEGOTIABLE

Every staff member present during operating hours — not only certified instructors — is genuinely trained and able to use the AED and perform CPR, not limited to whichever certified instructor happens to be nearby when a cardiac event occurs.

In plain terms: Everyone on duty — reception, cleaner, sales, not just instructors — can use the AED and do CPR, and has practised.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

The person nearest the collapse may be the receptionist. If only instructors are trained, the receptionist runs to find one while the member's brain goes without oxygen. Every staff member on the premises during opening hours — including part-time, evening, and weekend staff — must be trained and confident. AEDs are designed for lay use; the training is a few hours; the drills keep it fresh. The standard is 'every staff member present,' not 'someone in the building.'

WHAT GOOD LOOKS LIKE

- Every staff member present, not only instructors, is genuinely trained and capable.
- Training is genuinely current across all staff roles.
- Non-instructor staff report genuine confidence responding to a cardiac event.

COMMON FAILURE MODES

- CPR/AED capability is limited to certified instructors alone.
- Training has lapsed for staff outside direct instruction roles.
- Non-instructor staff express genuine uncertainty about responding.

WORKED EXAMPLE

IN PRACTICE

A 1,500-member fitness centre where CPR/AED training was for instructors only.

BEFORE	Reception, sales, and cleaning staff had no training. On a Sunday evening with one instructor on site, a member collapsed near reception; the receptionist did not know where the AED was or how to start CPR; the instructor was in a studio two floors up.
ACTION	All staff — every role, every shift — completed CPR/AED training funded by the facility, with certification tracked. New staff are trained within their first month, before solo shifts. Quarterly drills involve whoever is on duty. AED locations are covered at induction for everyone.
AFTER	The Monitor reviewed training records for all 42 staff (100% current) and asked a cleaner and a receptionist to locate the AED and describe the first steps; both did. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every staff member and whether they have CPR/AED training. Include cleaners and reception.
2. Train everyone.
3. Train new staff before their first solo shift.
4. Include all roles in drills.

The most common mistake: Training instructors only — the receptionist is the one at the front door when the member collapses.

SELF-ASSESSMENT QUESTIONS

1. Can every staff member present during operating hours, not only certified instructors, actually use the AED and perform CPR? —
Genuine, broad capability across all staff, not limited to certified

instructors alone.

Evidence: Staff CPR/AED training record

2. Is this training genuinely current for every staff member, not lapsed for those in non-instructor roles? — *Real, current training for everyone present, not only those whose primary role involves direct exercise instruction.*

Evidence: N/A — tested directly

3. Would a staff member confidently know what to do if a cardiac event occurred and no certified instructor were immediately nearby? — *Genuine, confident readiness, not uncertainty about acting without an instructor present.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Front-desk and administrative staff receive initial training but refreshers lapse more than for instructors.** — Every staff member's readiness deserves the same genuine, ongoing reinforcement, not just instructors'.
- **Training is broad but confidence varies significantly among non-instructor staff.** — Training completion alone doesn't guarantee the genuine, confident readiness a real emergency requires.
- **Coverage is strong during peak hours but thinner during early morning or late evening shifts.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current CPR/AED training coverage across all staff roles and shifts.
Week 2	Extend training to all staff present during operating hours, not instructors alone.
Week 3	Establish a consistent refresher schedule across all roles.
Ongoing	Confirm coverage specifically during lower-staffed shifts.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Broad training record review	Reviews CPR/AED training records for all staff present during operating hours, not only instructors.
DOCUMENT	Currency review	Reviews whether training is genuinely current across all staff roles.
ASK	Non-instructor confidence interview	Asks a non-instructor staff member how confident they'd be responding to a cardiac event.

SUPERVISOR TIPS

- **Ask a front-desk or administrative staff member directly whether they're trained and confident in CPR/AED use.** — This tests whether genuine capability extends beyond instructors, not an assumption it does.
- **Check training currency specifically for staff working early morning or late evening shifts.** — This is where coverage gaps most commonly appear.

EVIDENCE BASE

[13] Early CPR and early defibrillation are established as the critical links in the chain of survival for cardiac arrest, with survival highest when both occur within the first minutes of collapse, establishing broad staff response capability, not reliance on a single certified individual, as necessary for genuine emergency readiness.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

3.4 A Cardiac Event Triggers an Immediate, Practiced Response, Not Improvisation

NON-NEGOTIABLE

The facility maintains a specific, practiced emergency response protocol for a cardiac event — clear roles, a

defined communication process, a rehearsed sequence of actions — not a general expectation that staff will respond appropriately in the moment without ever having practiced it.

In plain terms: There is a written cardiac emergency plan with roles — who starts CPR, who fetches the AED, who calls the ambulance, who manages the crowd — and it is practised every quarter.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

In a cardiac arrest, the first four minutes decide the outcome, and in those minutes there is no time to decide who does what. A written protocol assigns roles by position (the nearest staff member starts CPR; the second fetches the AED; the receptionist calls emergency services and gives the address; the manager clears the area and meets the ambulance). Everyone knows their role. Quarterly drills — timed, with a debrief — turn the plan into reflex. A facility that has never drilled will improvise, and improvisation costs minutes.

WHAT GOOD LOOKS LIKE

- A specific, defined emergency response protocol genuinely exists.
- The protocol has been genuinely practiced through real drills.
- Staff roles are specifically defined and confidently known.

COMMON FAILURE MODES

- No specific protocol exists beyond a general expectation of appropriate response.
- The protocol exists only in writing, never practiced through a drill.
- Staff are uncertain about their specific role during a cardiac emergency.

WORKED EXAMPLE

IN PRACTICE

A 1,300-member fitness centre with trained staff but no protocol or drills.

BEFORE	Staff were CPR-trained. No written protocol; no drills. In a real event, three staff started CPR simultaneously, nobody fetched the AED for two minutes, and the ambulance was called late because everyone assumed someone else had.
ACTION	A one-page cardiac emergency protocol with role cards was written. Roles are by position, not name. The AED and emergency number are on every card. Quarterly drills with a mannequin, timed from 'collapse' to AED shock and to ambulance call, with a debrief and actions. Drill times are tracked. A real event review process was defined.
AFTER	The Monitor reviewed the protocol, four drill records (time to AED shock improved from 3:40 to 1:50), and debrief actions. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Write a one-page protocol with roles by position.
2. Put role cards at reception and in every studio.
3. Run a timed drill this month.
4. Debrief and repeat quarterly.

The most common mistake: Training everyone in CPR and assuming they will coordinate themselves in the moment.

SELF-ASSESSMENT QUESTIONS

1. Does the facility maintain a specific, defined emergency response protocol for a cardiac event? — *A real, specific protocol with defined roles, not a general expectation of appropriate response.*

Evidence: Cardiac emergency response protocol

2. Has this protocol genuinely been practiced through a real drill, not only described in a written document? — *Real, rehearsed practice, not a protocol that exists only on paper.*

Evidence: Drill record

3. Are staff roles specifically defined for this scenario — who calls emergency services, who retrieves the AED, who begins CPR? —

Specific, practiced role clarity, not general awareness that everyone should help.

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A protocol exists and has been drilled, but not recently enough to remain genuinely fresh for current staff.** — Genuine readiness depends on recent, real practice, not a drill from long ago.
- **Roles are clear for full-time staff but not consistently reinforced for newer or part-time team members.** — Every staff member present during a real emergency needs the same genuine role clarity.
- **The protocol covers the main exercise floor but hasn't specifically been drilled for a less typical area, like an outdoor space.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current emergency response protocol for specificity and genuine practice history.
Week 2	Define specific staff roles for cardiac emergency response.
Week 3	Conduct a genuine, practiced drill covering the full protocol.
Ongoing	Repeat drills periodically, ensuring newer staff are included.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Protocol documentation review	Reviews the actual, specific cardiac emergency response protocol.
DOCUMENT	Drill record review	Reviews records of genuine, practiced emergency drills, not protocol description alone.
ASK	Role clarity interview	Asks staff to describe their specific role during a cardiac emergency response.

SUPERVISOR TIPS

- **Ask staff to describe their specific role during a cardiac emergency, not a general description of the protocol.** — A specific, confident answer reveals genuine, practiced readiness.
- **Ask when the last real drill occurred and who participated.** — A specific, recent answer reveals genuine practice, not a protocol that exists only on paper.

EVIDENCE BASE

[14] The chain of survival for cardiac arrest specifically requires early recognition, early CPR, early defibrillation, and early advanced care as coordinated, sequential actions, establishing a genuinely practiced, defined response protocol as necessary, distinct from improvised action in the moment.

[**ASF training courses on GMJ Academy →**](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

3.5

Post-Event Review Genuinely Examines Response Time and Outcome

CORE

Following any real cardiac event or drill, the facility genuinely reviews actual response time and outcome — how long until the AED arrived, how long until the first shock — with real, resulting improvement where warranted, not an event that passes without any structured reflection on what actually happened.

In plain terms: After any real cardiac event or drill, the facility reviews what actually happened — time to CPR, time to AED, time to ambulance — and fixes what was slow.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

A drill or a real event that is not reviewed teaches nothing. The review asks: how long from collapse to CPR? To AED on? To shock? To ambulance called? To ambulance arrived? What delayed each? Then: what changes? A door that was locked, a staff member who froze, an AED that was further than thought, a phone that was engaged. Each finding becomes an action. Response times tracked over successive drills show whether the facility is getting faster.

WHAT GOOD LOOKS LIKE

- Real response time is genuinely measured and reviewed following events or drills.
- Genuine, resulting improvement follows identified gaps.
- Drills receive the same genuine review attention as real events.

COMMON FAILURE MODES

- No genuine review of actual response time occurs.
- Review, if it happens, doesn't lead to any resulting improvement.
- Drills are treated as a lesser exercise, without the same genuine review.

WORKED EXAMPLE

IN PRACTICE

A 1,400-member fitness centre running quarterly drills without structured review.

BEFORE

Drills happened. Afterwards, staff said 'that went fine.' No timing, no debrief, no actions. The same problems — nobody calling the ambulance, the AED cabinet key missing — recurred every drill.

ACTION

A post-event review template was introduced: timeline with timestamps, what went well, what delayed, root cause of each delay, actions with owners. Every drill and real event is reviewed within 48 hours. Times are charted. Actions are tracked to completion. The AED cabinet key issue was resolved by removing the lock.

AFTER

The Monitor reviewed four drill reviews with timelines, delay analysis, and completed actions;

time to shock trend showed improvement.
Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Time your next drill: collapse to CPR, to AED, to shock, to call.
2. Ask what delayed each step.
3. Write one action per delay.
4. Chart the times across drills.

The most common mistake: 'That went fine' — the drill that is not timed cannot be improved.

SELF-ASSESSMENT QUESTIONS

1. Does the facility genuinely review actual response time following a real event or drill? — *Real, specific measurement of actual time, not a general sense that response was adequate.*

Evidence: Post-event review documentation

2. Is genuine, resulting improvement made where review identifies a real gap? — *Real, resulting action, not review without any consequence.*

Evidence: Improvement action record

3. Are drills specifically reviewed the same way as real events, not treated as a lesser exercise? — *Genuine, equal attention to drills, not only real emergencies.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Response time is generally discussed after an event but not specifically, numerically measured.** — A specific, measured time reveals genuine performance more reliably than a general impression.
- **Review happens for real events but drills don't consistently receive the same structured attention.** — Drills are the primary, regular opportunity to catch and correct gaps before a real event occurs.
- **Findings are identified but resulting changes aren't consistently tracked to confirm implementation.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for genuine response time measurement following events or drills.
Week 2	Establish a structured review process specifically measuring actual response time.
Week 3	Build genuine review attention for drills, equal to real events.
Ongoing	Track identified improvements through to confirmed implementation.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Post-event review documentation review	Reviews evidence of genuine response time measurement following real events or drills.
DOCUMENT	Improvement action review	Reviews whether genuine, resulting improvement follows identified review findings.
ASK	Drill review interview	Asks staff whether drills receive the same genuine review as real events.

SUPERVISOR TIPS

- **Ask for the actual, measured response time from the most recent drill.** — A specific, real number reveals genuine measurement, not a general impression of adequacy.
- **Ask what changed as a result of the most recent drill review.** — A real, specific example reveals whether review leads to genuine improvement.

EVIDENCE BASE

[15] On-site AED use is associated with meaningfully faster time to first shock compared with externally delivered defibrillation, establishing genuine measurement of actual response time as necessary to confirming a facility's real readiness matches the evidence-based standard, not merely assumed adequate.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Fitness & Wellness
Standards — all standards**

**Self-assess against these
criteria →**

← **Standard 2 — Exercise
Supervision & Instructor
Qualification**

**Standard 4 — Equipment
Safety & Facility
Environment →**

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ASF STANDARDS · FITNESS & WELLNESS · STANDARD 4

Standard 4 — Equipment Safety & Facility Environment

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

- 4.1 — Equipment Inspection Follows a Genuine, Tiered Schedule
- 4.2 — Treadmill Safety Features Are Verified Functional, Not Assumed Present
- 4.3 — Equipment Spacing Genuinely Supports Safe, Accessible Pathways
- 4.4 — Malfunctioning Equipment Is Immediately Tagged Out of Service
- 4.5 — Facility Environment Genuinely Supports Safe Exercise

4.1 Equipment Inspection Follows a Genuine, Tiered Schedule

NON-NEGOTIABLE

Exercise equipment is inspected on a genuine, tiered schedule — a quick check before each use, a more thorough inspection daily or weekly covering bolts, cables, and belts, and a deep maintenance inspection following manufacturer guidelines — not a single, informal check treated as sufficient for every level of real wear.

In plain terms: Equipment is inspected on three levels — a quick look before each use, a thorough weekly check by staff, and a periodic professional service — with records.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A cable that frays, a treadmill belt that slips, a weight stack pin that bends, a bolt that loosens — each becomes an injury if nobody looks. Tiered inspection catches failures at different stages: the daily pre-use glance (frayed cable, loose part, unusual noise) by staff opening the floor; the weekly structured check (cables, belts, pins, bolts, upholstery, safety features) with a checklist; the professional service per manufacturer schedule (usually quarterly to annually). Records for all three. A facility with only the professional service has weeks of unnoticed deterioration between visits.

WHAT GOOD LOOKS LIKE

- A genuine before-use check is consistently practiced.
- Thorough daily or weekly inspection is genuinely documented.
- Deep maintenance follows manufacturer-specific schedules, not a generic interval.

COMMON FAILURE MODES

- No genuine before-use check happens; equipment use begins without any real verification.
- Thorough inspection, if it happens, isn't documented or scheduled.
- Deep maintenance follows a generic schedule unrelated to manufacturer guidance.

WORKED EXAMPLE

IN PRACTICE

A 1,500-member fitness centre with an annual service contract and no in-house inspection.

BEFORE

Equipment was serviced annually. Between services, faults were found by members. A cable machine's frayed cable snapped during use,

	injuring a member; the fray had been visible for weeks.
ACTION	A tiered inspection schedule was set: daily pre-opening walk-round with a 10-point checklist per area; weekly structured inspection of every item with a manufacturer-based checklist, logged; quarterly professional service per manufacturer schedule. Faults found at any tier are tagged out (4.4). The fitness manager reviews logs weekly.
AFTER	The Monitor reviewed 12 weeks of daily and weekly logs, the service contract and last service report, and observed the daily walk-round. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. When was each item of equipment last inspected by your own staff?
2. Write a daily walk-round checklist and a weekly per-item checklist.
3. Log both.
4. Confirm the professional service schedule matches the manufacturer's.

The most common mistake: Relying on the annual service — the cable frays in month three.

SELF-ASSESSMENT QUESTIONS

1. Is there a genuine quick check performed before each use, not skipped as a formality? — *Real, consistent practice, not an assumption equipment is fine because it was fine yesterday.*

Evidence: Before-use check protocol

2. Does a more thorough inspection — bolts, cables, belts — genuinely happen daily or weekly, documented? — *A real, documented, scheduled inspection, not an informal glance.*

Evidence: Daily/weekly inspection record

3. Does deep maintenance inspection genuinely follow manufacturer guidelines on the recommended schedule? — *Real, scheduled*

compliance with manufacturer-specific requirements, not a generic interval applied to all equipment.

Evidence: Deep maintenance schedule documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Daily inspection happens for cardio equipment but less consistently for strength and free-weight areas.** — Every equipment category carries genuine, real failure risk deserving the same inspection discipline.
- **Deep maintenance is scheduled but occasionally delayed when the facility is busy.** — A schedule that slips under operational pressure doesn't provide the genuine protection it's designed for.
- **Documentation exists for inspections but isn't reviewed to confirm they're genuinely happening as scheduled.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current equipment inspection practice against the genuine, tiered standard.
Week 2	Establish or strengthen documented daily or weekly inspection covering bolts, cables, and belts.
Week 3	Confirm deep maintenance scheduling matches specific manufacturer guidelines for each equipment type.
Ongoing	Audit inspection documentation to confirm genuine, consistent compliance.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Before-use check observation	Observes whether a genuine before-use check practice is actually followed.
DOCUMENT	Daily/weekly inspection review	Reviews documented records of thorough, scheduled inspection covering bolts, cables, and belts.
DOCUMENT	Deep maintenance schedule review	Reviews whether deep maintenance follows the specific manufacturer-recommended schedule for each equipment type.

SUPERVISOR TIPS

- **Ask to see the actual, current inspection log, not a general assurance equipment is checked.** — A real, specific record reveals genuine practice, not an assumption of adequacy.
- **Ask when the most recent deep maintenance inspection occurred for a specific piece of equipment.** — A specific, real date reveals whether the schedule is genuinely followed, not just described in policy.

EVIDENCE BASE

[16] Recognised fitness equipment maintenance practice establishes a genuine, tiered inspection schedule: a quick visual and functional check before each use, a more thorough inspection of bolts, cables, and belts on a daily or weekly basis, and deep maintenance inspection following manufacturer guidelines, distinct from a single, undifferentiated check.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

4.2 Treadmill Safety Features Are Verified Functional, Not Assumed Present

NON-NEGOTIABLE

Every treadmill's emergency stop mechanism — the safety key or clip designed to immediately halt the belt — is verified genuinely present and functional through active testing, not assumed to work because it's physically attached to the machine.

In plain terms: Every treadmill's emergency stop — the safety key or clip — is tested and confirmed working, and members are shown how to use it.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A treadmill safety key stops the belt when the user falls. If the key is missing, disconnected, or the mechanism has failed, a member who trips is dragged. Treadmill injuries are among the most common and most serious in fitness facilities. Each treadmill's stop must be tested (pull the key, confirm the belt stops) on the weekly inspection; missing keys replaced; and members shown the key at induction and reminded by signage. A treadmill whose stop has never been tested is a treadmill whose stop may not work.

WHAT GOOD LOOKS LIKE

- Every treadmill's emergency stop mechanism is actively, genuinely tested.
- Testing is integrated into the scheduled inspection process.
- Non-functional mechanisms result in immediate, genuine removal from service.

COMMON FAILURE MODES

- Emergency stop function is assumed from physical presence, never actively tested.
- Testing, if it happens, is separate and easily overlooked.
- Equipment with a known non-functional mechanism remains available for use.

WORKED EXAMPLE

IN PRACTICE

A 1,200-member fitness centre with 20 treadmills.

BEFORE

Safety keys were often missing (members removed them). Nobody tested the stop function. Two treadmills had disconnected stop switches after a repair. Members were not shown the key at induction.

ACTION

The weekly inspection includes pulling every treadmill's safety key and confirming the belt stops. Keys are tethered to the machine. Missing or non-functional stops tag the treadmill out (4.4). Induction includes a demonstration of the safety clip and members are asked to attach it. Signage on every treadmill shows the clip.

AFTER

The Monitor tested five treadmills' safety keys (all stopped the belt), reviewed weekly inspection logs, and observed an induction including the clip demonstration. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull the safety key on every treadmill today. Does the belt stop?
2. Tether the keys to the machines.
3. Add the test to the weekly inspection.
4. Show every member the clip at induction.

The most common mistake: Assuming the safety key works because it is present.

SELF-ASSESSMENT QUESTIONS

1. Is every treadmill's emergency stop mechanism actively tested, not just visually confirmed as present? — *Real, active functional testing, not an assumption it works because it's attached.*

Evidence: Emergency stop function test record

2. Is this testing genuinely part of the scheduled inspection process, not a separate, easily overlooked step? — *Integrated, scheduled testing, not something that can quietly be skipped.*

Evidence: N/A — tested directly

3. Is a treadmill with a non-functional emergency stop immediately taken out of service, not left available? — *Real, immediate removal from use, not continued availability with a known, unresolved safety gap.*

Evidence: Out-of-service protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Testing happens but isn't performed with the same consistency across every treadmill in the facility.** — Every treadmill carries the same real risk and deserves the same genuine testing discipline.
- **A non-functional mechanism is identified but the equipment isn't removed from service immediately.** — A known, unresolved safety gap left available provides no real protection during the delay.
- **Testing occurs during scheduled maintenance but member-reported concerns between scheduled checks aren't consistently investigated immediately.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current treadmill emergency stop verification for genuine, active testing.
Week 2	Integrate active emergency stop testing into scheduled inspection for every treadmill.
Week 3	Establish an immediate out-of-service protocol for any identified non-function.
Ongoing	Investigate member-reported concerns about emergency stop function immediately.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Emergency stop function test	Actively tests a sample of treadmill emergency stop mechanisms for genuine function.
DOCUMENT	Testing schedule review	Reviews whether emergency stop testing is genuinely integrated into scheduled inspection.
DOCUMENT	Out-of-service review	Reviews whether equipment with a non-functional emergency stop is genuinely, immediately removed from availability.

SUPERVISOR TIPS

- **Ask staff to actively test a treadmill's emergency stop mechanism in front of you.** — Direct, live testing reveals genuine function, not an assumption based on the mechanism's presence.
- **Ask what happens specifically if a member reports an emergency stop that doesn't seem to work.** — A specific, confident answer reveals a genuine, immediate response process.

EVIDENCE BASE

[17] The Consumer Product Safety Commission has documented hundreds of incidents involving individuals being pulled under moving treadmill belts, establishing genuine, active verification of treadmill emergency stop mechanisms as necessary, distinct from assumed function based on physical presence alone.

[ASF training courses on GMJ Academy →](#)

4.3

Equipment Spacing Genuinely Supports Safe, Accessible Pathways

CORE

Cardio and strength equipment is genuinely spaced to maintain safe, accessible pathways between machines — a real, measured minimum distance, not equipment positioned as closely together as physically possible to maximize floor capacity.

In plain terms: Machines are spaced so members can move safely between them, someone can reach a collapsed member, and a wheelchair user can get around — not packed as tightly as possible.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

A weight bench 30 cm from a treadmill means a falling member hits the bench. A rack of dumbbells against a machine means the user cannot step back safely. A gym floor with no clear path means a staff member cannot reach a collapse with the AED, and a member with a disability cannot use the facility. Guidance (ACSM, national standards) sets minimum clearances: typically 90 cm between machines, 1 metre behind treadmills, 1.2 metre main pathways. The facility measures, reconfigures, and keeps the paths clear.

WHAT GOOD LOOKS LIKE

- Equipment spacing genuinely meets the recognised minimum distance standard.
- Spacing has been physically measured, not visually estimated.
- Pathways genuinely accommodate mobility aid

COMMON FAILURE MODES

- Equipment is spaced more closely than the recognised minimum standard.
- Spacing adequacy is assumed from visual impression, never physically measured.

users, not just able-bodied movement.

- Pathways don't genuinely accommodate mobility aid users.

WORKED EXAMPLE

IN PRACTICE

A 1,600-member fitness centre that had added equipment over years without a layout plan.

BEFORE

Equipment was packed to maximise count. Clearances were under 50 cm in places. A member fell from a treadmill onto an adjacent bench. Staff could not get a stretcher through the free-weights area. A wheelchair user could not access the cardio area.

ACTION

The floor was measured against ACSM clearances. Fourteen items were relocated or removed. Main pathways of 1.2 metres were marked on the floor. Treadmills have 1 metre clear behind. An accessible route to every area was established. The layout is documented; any new equipment must fit the plan.

AFTER

The Monitor measured clearances in four areas (all meeting guidance), walked the accessible route, and reviewed the layout plan. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Measure the clearance between machines in your busiest area.
2. Compare to ACSM or national guidance.
3. Move or remove what does not fit.
4. Mark main pathways on the floor.

The most common mistake: Adding one more machine because there is a gap — the gap was the safety clearance.

SELF-ASSESSMENT QUESTIONS

1. Is equipment genuinely spaced to maintain the recognised minimum distance for safe, accessible pathways? — *A real, measured spacing standard, not equipment positioned for maximum density.*

Evidence: Equipment spacing verification

2. Has this spacing been physically measured, not just visually estimated as adequate? — *Real, physical measurement, not a general impression of sufficient space.*

Evidence: N/A — tested directly

3. Do pathways genuinely accommodate a member using a mobility aid, not just an able-bodied member moving freely? — *Genuine accessibility for mobility aid users specifically, not assumed adequate from general spacing alone.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Spacing meets the standard in the main equipment area but not in a secondary or overflow space.** — Every area where equipment is used deserves the same genuine spacing standard.
- **Spacing was adequate at initial layout but has narrowed as additional equipment was added over time.** — Spacing needs to be genuinely reverified whenever the equipment layout changes, not assumed to remain constant.
- **General pathways are adequate but specific transition points, like between equipment rows, are narrower.**

IMPLEMENTATION PLAN

When	What
Week 1	Physically measure current equipment spacing against the recognised minimum standard.
Week 2	Address any area falling short of the standard.
Week 3	Specifically verify pathway accessibility for mobility aid users.
Ongoing	Reverify spacing whenever equipment layout changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Spacing measurement	Physically measures spacing between equipment against the recognised minimum standard.
DOCUMENT	Layout documentation review	Reviews facility layout documentation for genuine, measured spacing compliance.
OBSERVE	Mobility aid accessibility check	Assesses whether pathways genuinely accommodate a member using a mobility aid.

SUPERVISOR TIPS

- **Physically measure spacing between a sample of equipment pieces directly.** — Direct measurement reveals genuine compliance, not a visual impression of adequate space.
- **Walk the pathways as a mobility aid user would need to.** — This tests genuine accessibility, not just general spacing sufficiency for able-bodied movement.

EVIDENCE BASE

[18] Established fitness facility safety practice requires cardio equipment to be spaced at least 19.7 inches apart to maintain accessible pathways, reflecting a genuine, measured minimum distance rather than equipment density prioritized over safe access.

ASF training courses on GMJ Academy —

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

4.4 Malfunctioning Equipment Is Immediately Tagged Out of Service

NON-NEGOTIABLE

Equipment identified as malfunctioning — through inspection, staff observation, or member report — is immediately, visibly tagged out of service and genuinely

prevented from use, not left available while awaiting repair or treated as a minor issue members can work around.

In plain terms: The moment a piece of equipment is found faulty — by inspection, staff, or a member — it is tagged 'out of service' and cannot be used until fixed.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A faulty machine that stays on the floor will be used. Members do not read small notes; a machine that looks available is available. Tagging out means: a visible, standard 'OUT OF SERVICE — DO NOT USE' tag; where possible, the machine disabled (unplugged, pin removed) or physically blocked; a log entry with the fault, date, and person; repair requested; the tag removed only after repair is verified. Any staff member can tag out. A member report is treated as a fault until proven otherwise.

WHAT GOOD LOOKS LIKE

- Malfunctioning equipment is immediately, visibly tagged and genuinely restricted from use.
- Physical prevention, not just a sign, keeps the equipment genuinely inaccessible.
- Staff and members clearly understand tagged equipment is genuinely off-limits.

COMMON FAILURE MODES

- Malfunctioning equipment remains available while awaiting eventual repair.
- A sign is posted but the equipment remains physically accessible.
- Staff or members treat a tagged item as an informal suggestion, not a genuine restriction.

WORKED EXAMPLE

IN PRACTICE

A 1,400-member fitness centre where faulty equipment was noted on a whiteboard in the office.

BEFORE

Faults were written on an office whiteboard. Machines stayed on the floor. Members used

	them. A leg press with a known faulty safety catch was used for a week before repair; a member was injured.
ACTION	Standard red tags were placed at every staff station. Any staff member tags out any fault immediately, disables the machine where possible, and logs it. Member reports are tagged pending inspection. Repair requests go the same day. The tag is removed only when the fitness manager verifies the repair. The log is reviewed weekly.
AFTER	The Monitor found two tagged machines with matching log entries and repair requests, and reviewed three months of the tag-out log with repair verifications. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Walk the floor now. Is there any machine with a known fault still available?
2. Buy red 'OUT OF SERVICE' tags and give every staff member authority to use them.
3. Log every tag-out.
4. Remove tags only after verified repair.

The most common mistake: A note in the office about a fault the members on the floor cannot see.

SELF-ASSESSMENT QUESTIONS

1. Is malfunctioning equipment immediately, visibly tagged out of service upon identification? — *Real, immediate, visible action, not equipment left available while awaiting eventual repair.*

Evidence: Out-of-service tagging protocol

2. Is this equipment genuinely, physically prevented from use, not just marked while remaining accessible? — *Real, physical prevention of use, not a sign alone without actual access restriction.*

Evidence: N/A — tested directly

3. Are staff and members alike aware that a tagged item is genuinely off-limits, not an informal suggestion? — *Genuine, clear communication that use is prohibited, not merely discouraged.*
Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Tagging happens reliably for equipment identified during scheduled inspection but less consistently for member-reported issues.** — A member-reported malfunction carries the same real, immediate risk as one found during scheduled inspection.
- **Equipment is tagged but physical access isn't consistently restricted, relying on the sign alone.** — Genuine restriction requires more than a sign a member might reasonably overlook or disregard.
- **Tagging happens promptly during staffed hours but response is slower during lower-staffed periods.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current out-of-service practice for genuine, immediate tagging and physical restriction.
Week 2	Establish a clear, defined protocol for immediate tagging following any identification method.
Week 3	Build genuine physical restriction, not signage alone, for tagged equipment.
Ongoing	Audit response time for member-reported malfunctions specifically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Tagging practice observation	Observes whether malfunctioning equipment is genuinely, immediately tagged and physically restricted.
DOCUMENT	Protocol documentation review	Reviews the specific, defined out-of-service protocol.

Method	What	Detail
ASK	Staff and member awareness interview	Asks staff and a member whether a tagged item is genuinely understood as off-limits.

SUPERVISOR TIPS

- **Ask for a real, recent example of equipment being tagged out of service and how quickly it happened.** — A real, traced example reveals whether tagging is genuinely immediate, not just policy language.
- **Check whether a tagged item, if one currently exists, is genuinely physically inaccessible.** — Direct observation reveals whether restriction is real, not just a sign a member could disregard.

EVIDENCE BASE

[19] Malfunctioning fitness equipment has resulted in documented, serious injury including spinal injury from equipment failure, establishing immediate, visible removal from availability upon identification of malfunction as necessary, distinct from continued availability pending eventual repair.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

4.5 Facility Environment Genuinely Supports Safe Exercise

NON-NEGOTIABLE

The facility's physical environment — flooring condition, ventilation, cleanliness of shared surfaces — genuinely supports safe exercise, not merely meets a minimum documented standard while real, everyday conditions tell a different story.

In plain terms: The floor is even and non-slip, the air is fresh, shared surfaces are cleaned, and the environment is checked — not just the equipment.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A worn floor tile trips a member. A stuffy studio causes fainting. A bench that is never wiped spreads skin infections. The environment injures as surely as equipment. A regular environmental check — flooring condition, spills and mats, ventilation and temperature, cleanliness of shared surfaces and changing rooms, lighting, water availability — with a log and a fix-by process, keeps the facility safe to be in. Members should have wipes and be expected to use them; staff should clean high-touch surfaces on a schedule.

WHAT GOOD LOOKS LIKE

- Flooring genuinely supports safe exercise, verified through direct inspection.
- Ventilation is genuinely adequate during exertion-level activity, not just at rest.
- Shared surfaces are genuinely, regularly cleaned through facility-driven practice.

COMMON FAILURE MODES

- Flooring condition is assumed acceptable without genuine, current inspection.
- Ventilation is comfortable at rest but inadequate during actual exertion.
- Cleaning relies solely on individual members, with no facility-driven schedule.

WORKED EXAMPLE

IN PRACTICE

A 1,300-member fitness centre with equipment inspection but no environmental check.

BEFORE

Floor tiles were cracked in two areas. The spin studio had no functioning ventilation; members reported dizziness. Benches were wiped 'when they looked dirty.' A skin infection outbreak was traced to the free-weights area.

ACTION

An environmental check was added to the daily walk-round: flooring, spills, ventilation, temperature, surface cleanliness, changing

rooms, lighting, water. Findings are logged and fixed. Cracked tiles were replaced. Ventilation in the spin studio was repaired and air changes verified. A surface cleaning schedule was set (high-touch every two hours, all equipment daily) and logged. Wipe stations were installed in every area.

AFTER

The Monitor walked the facility with the checklist (all items met), reviewed daily logs and the cleaning schedule, and checked the spin studio ventilation. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Walk the facility with a 10-item environmental checklist.
2. Fix the worst three things.
3. Add the checklist to the daily walk-round.
4. Set a surface cleaning schedule and install wipe stations.

The most common mistake: Inspecting the machines and ignoring the floor they stand on.

SELF-ASSESSMENT QUESTIONS

1. Does flooring genuinely support safe exercise — free of damage, appropriate for the activity — not just appear acceptable? — *Real, verified flooring condition, not a general visual impression.*

Evidence: Flooring condition documentation

2. Is ventilation genuinely adequate for exertion-level activity, not just comfortable at rest? — *Real, activity-appropriate ventilation, not assumed adequate from general comfort.*

Evidence: N/A — tested directly

3. Are shared equipment surfaces genuinely, regularly cleaned, not left to member self-wipe alone? — *Real, facility-driven cleaning practice, not sole reliance on individual members to maintain hygiene.*

Evidence: Cleaning schedule documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Flooring is well-maintained in the main area but a secondary space hasn't been recently inspected.** — Every area where

exercise occurs deserves the same genuine attention to flooring safety.

- **Ventilation is adequate on typical days but noticeably strained during peak attendance.** — Genuine adequacy needs to hold specifically when demand is highest, not only under typical conditions.
- **A cleaning schedule exists but isn't consistently followed during high-volume periods.**

IMPLEMENTATION PLAN

When	What
Week 1	Physically assess flooring, ventilation, and cleaning practice for genuine, real-world adequacy.
Week 2	Address any flooring condition issue identified in less-monitored areas.
Week 3	Assess ventilation specifically during peak attendance periods.
Ongoing	Confirm cleaning schedule adherence during high-volume periods specifically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Flooring condition observation	Physically inspects flooring for genuine, current condition and appropriateness to activity.
OBSERVE	Ventilation assessment	Assesses ventilation adequacy specifically during periods of active, exertion-level use.
DOCUMENT	Cleaning schedule review	Reviews the facility's own cleaning schedule for shared equipment surfaces, not reliance on member self-wipe alone.

SUPERVISOR TIPS

- **Physically inspect flooring directly, including in secondary or less-visited areas.** — Direct observation reveals genuine condition, not assumed adequacy from general impression.
- **Ask about ventilation specifically during the facility's busiest period.** — This is where environmental adequacy is most likely to be genuinely tested.

EVIDENCE BASE

[20] Established fitness facility safety practice requires genuine attention to flooring condition, ventilation, and shared surface hygiene as core components of facility environment safety, distinct from equipment-specific safety considered in isolation from the broader physical environment.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Fitness & Wellness
Standards — all standards**

**Self-assess against these
criteria →**

← **Standard 3 — Emergency
Preparedness & Cardiac
Event Response**

**Standard 5 — Program
Design & Individualization →**

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ASF STANDARDS · FITNESS & WELLNESS · STANDARD 5

Standard 5 — Program Design & Individualization

5 criteria · 3 non-negotiable · 2 core · Version 3.0

CRITERIA IN THIS STANDARD

5.1 — Every Program Is Built Using the FITT-VP Framework, Not a Generic Template

5.2 — Progressive Overload Is Genuinely Gradual, Not "Too Much, Too Soon"

5.3 — Programs for Members With Identified Health Conditions Are Specifically Adapted

5.4 — Rest and Recovery Are Genuinely Built Into the Program

5.5 — Programs Are Actively Reviewed and Adjusted as Fitness Changes

5.1 Every Program Is Built Using the FITT-VP Framework, Not a Generic Template

NON-NEGOTIABLE

Every member's exercise program is genuinely designed using the FITT-VP framework — frequency, intensity, time, type, volume, and progression, each specifically set for that individual — not a generic template applied to every member regardless of their actual goals, fitness level, or health status. The program is built by a qualified individual, drawing in other relevant disciplines where the member's

health status calls for it, and states explicit goals the member genuinely helped set.

In plain terms: Every member's programme is built from the FITT-VP principles — frequency, intensity, time, type, volume, progression — for that individual, not copied from a template.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A programme handed to every new member regardless of their fitness, goals, or health is a template, not a programme. FITT-VP is the evidence-based framework: how often (frequency), how hard (intensity), how long (time), what (type), total load (volume), and how it advances (progression) — each set for this person from their assessment. The programme is written, the reasoning is visible, and it changes as the member changes (5.5). A member on a template that does not fit them is a member who will plateau, get bored, or get hurt.

WHAT GOOD LOOKS LIKE

- Every program is genuinely designed using the full FITT-VP framework.
- All six variables are specifically, deliberately set for the individual.
- Staff can explain the specific, individual rationale behind program design.

COMMON FAILURE MODES

- Programs follow a generic template applied regardless of individual circumstances.
- Some FITT-VP variables default to a generic setting, not individually determined.
- Staff cannot explain why a specific program was designed as it was.

WORKED EXAMPLE

IN PRACTICE

A 1,500-member fitness centre using three standard programmes by goal.

BEFORE

Members received 'weight loss,' 'muscle gain,' or 'general fitness' programmes from a printed set.

	No individualisation. A 65-year-old beginner and a 25-year-old athlete with the same goal got the same programme.
ACTION	The programme template was rebuilt around FITT-VP: each element is specified per member from their screening, assessment, and goals, with the rationale noted. Trainers completed a programming course. Every programme is written by a qualified trainer after an assessment. A monthly audit of ten programmes checks individualisation.
AFTER	The Monitor reviewed 20 programmes with individualised FITT-VP elements and rationale, and the audit records. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull ten programmes. Cover the names. Can you tell the members apart?
2. Rebuild the template around FITT-VP with rationale fields.
3. Require an assessment before every programme.
4. Audit ten a month.

The most common mistake: Three printed programmes for 1,500 members.

SELF-ASSESSMENT QUESTIONS

1. Is every member's program genuinely designed using the FITT-VP framework, not a generic template? — *Real, individual-specific design across all six variables, not a template applied uniformly.*

Evidence: Individual program design documentation

2. Are frequency, intensity, time, type, volume, and progression each specifically, deliberately set for this individual? — *Genuine, deliberate setting of every variable, not some left at a generic default.*

Evidence: N/A — tested directly

3. Can staff explain why this specific program's variables were set the way they were for this specific member? — *A real, individual*

rationale, not a generic justification applicable to any member.

Evidence: N/A — tested directly

4. Is the program built by a qualified individual, with other relevant disciplines drawn in where the member's health status calls for it? —

A named, qualified instructor or trainer, with real referral when a member's condition exceeds that role's own scope.

Evidence: Program-builder qualification record

5. Does the program record state explicit goals, and was the member genuinely involved in setting them? —

A real, stated goal and genuine involvement, not a program designed and only handed to the member.

Evidence: Program goal documentation, member interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Intensity and type are individualized but frequency and volume default to a standard recommendation.** — Every one of the six variables carries real, individual significance, not only the most commonly adjusted ones.
- **Design is genuinely individualized for personal training clients but less so for group class participants.** — Individualization matters for every member's safety and effectiveness, not personal training clients alone.
- **Documentation exists but doesn't clearly capture the individual reasoning behind each variable.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current program design practice for genuine FITT-VP individualization versus generic templates.
Week 2	Train staff on deliberately setting all six FITT-VP variables for each individual.
Week 3	Extend individualized design practice to group class participants, not personal training alone.
Ongoing	Document the specific individual rationale behind program design decisions.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Program design review	Reviews individual program documentation for genuine FITT-VP-based design, not generic template application.
DOCUMENT	Variable-setting review	Reviews whether all six FITT-VP variables are specifically, deliberately set for the individual.
ASK	Rationale interview	Asks staff to explain the specific rationale behind a specific member's program variables.

SUPERVISOR TIPS

- **Ask staff to walk through the specific FITT-VP reasoning behind a real member's current program.** — A specific, real explanation reveals genuine individualization, not a generic template applied uniformly.
- **Compare two different members' programs to confirm genuine, meaningful variation.** — Genuinely different programs for genuinely different individuals reveal real individualization, not superficial variation.

EVIDENCE BASE

[21] The FITT-VP principle — frequency, intensity, time, type, volume, and progression — is established as the core structural framework for individualized exercise prescription, reflecting that a prescription effective for one individual may be entirely inappropriate for another.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

5.2 Progressive Overload Is Genuinely Gradual, Not "Too Much, Too Soon"

NON-NEGOTIABLE

Program progression genuinely increases demand gradually, allowing real recovery between increases — not

advancing intensity, volume, or frequency faster than the member's actual body can adapt to and recover from.

In plain terms: Programmes increase demand gradually — no more than about 10% a week — with recovery between increases, so members are not pushed into injury.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

'Too much, too soon' is the leading cause of exercise injury: the beginner who runs five days in the first week, the lifter who doubles the load after one session, the member who adds intensity and volume at once. Tissues adapt slowly; enthusiasm does not. Progressive overload done right increases one variable at a time, by a modest amount (the 10% guideline), with a recovery week periodically. The programme specifies the progression; the trainer checks it is followed; the member is educated. A facility whose programmes progress by feel will injure its keenest members.

WHAT GOOD LOOKS LIKE

- Progression genuinely increases demand gradually, matched to real recovery.
- Progression pace is individually adjusted, not fixed uniformly.
- A real process recognises and responds to signs of outpaced recovery.

COMMON FAILURE MODES

- Progression advances faster than genuine recovery can support.
- A fixed progression schedule is applied regardless of individual recovery.
- No process exists to recognise or respond to overtraining warning signs.

WORKED EXAMPLE

IN PRACTICE

A 1,400-member fitness centre with high injury rates among new members.

BEFORE	Progression was left to trainers and members. New members were encouraged to 'push hard.' The incident log showed overuse injuries concentrated in members' first two months.
ACTION	Progression rules were written into the programming standard: one variable at a time; increases of 5–10% per week; a lighter recovery week every fourth week; no increase if the member reports pain or excessive fatigue. Every programme shows the planned progression. Trainers check adherence at each review. Members receive a 'progression' briefing at induction.
AFTER	The Monitor reviewed 20 programmes with explicit progression plans and the injury log (new-member overuse injuries down 60%). Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Look at your injury log: are injuries clustered in the first two months?
2. Write progression rules: one variable, 5–10%, recovery week.
3. Show the progression in every programme.
4. Brief members at induction.

The most common mistake: Encouraging new members to 'push hard' — the ones who listen get injured.

SELF-ASSESSMENT QUESTIONS

1. Does progression genuinely increase demand gradually, allowing real recovery between increases? — *Real, gradual progression matched to actual recovery capacity, not advancement faster than the body can adapt.*

Evidence: Progression schedule documentation

2. Is progression pace specifically adjusted for an individual member, not a fixed schedule applied to everyone? — *Genuine, individual pacing, not a generic progression timeline regardless of*

individual recovery.

Evidence: N/A — tested directly

3. Is there a specific process for recognising signs a member's progression is outpacing their genuine recovery? — A real, active recognition process, not progression continuing regardless of warning signs.

Evidence: Overtraining recognition process

COMMON REASONS FOR A PARTIAL ANSWER

- **Progression pace is generally conservative but doesn't specifically account for a member's reported fatigue or soreness.** — Genuine individualization should respond to real, reported signals, not only a predetermined schedule.
- **Recognition happens for obvious signs of overtraining but subtler indicators are less consistently caught.** — Early recognition of subtler signs prevents the situation from progressing to something more serious.
- **Progression is gradual for new members but accelerates once a member is perceived as more experienced.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current progression practice for genuine, gradual pacing matched to individual recovery.
Week 2	Establish individual pacing adjustment based on reported fatigue and recovery signals.
Week 3	Train staff on recognising both obvious and subtler signs of outpaced recovery.
Ongoing	Review progression pacing periodically against actual member recovery patterns.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Progression pace review	Reviews program progression schedules for genuine, gradual pacing matched to recovery.
DOCUMENT	Individual pacing review	Reviews whether progression pace is individually adjusted, not fixed uniformly.

Method	What	Detail
ASK	Warning sign recognition interview	Asks staff how they recognise when a member's progression is outpacing genuine recovery.

SUPERVISOR TIPS

- **Ask how progression pace would change for a member reporting persistent soreness.** — A specific, thoughtful answer reveals genuine, individual responsiveness, not a fixed schedule.
- **Ask staff to describe subtler signs of overtraining, not only obvious ones.** — This reveals genuine, nuanced understanding, not surface-level awareness of the concept.

EVIDENCE BASE

[22] When training load exceeds genuine recovery capacity, the body cannot repair adequately before the next demand, resulting in increased weakness and injury risk rather than fitness adaptation, establishing gradual, recovery-matched progression as a genuine safety requirement, not solely an effectiveness consideration.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

5.3 Programs for Members With Identified Health Conditions Are Specifically Adapted

NON-NEGOTIABLE

A member with an identified health condition — from pre-participation screening or otherwise disclosed — receives a program specifically adapted to that condition, ideally under medical guidance where genuinely warranted, not a standard program applied as though the condition weren't a factor.

In plain terms: A member with a known health condition — heart disease, diabetes, pregnancy, arthritis, an injury — gets a programme specifically adapted for it by someone who knows how.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

This is 1.5 applied to the programme: the condition is not just noted; the programme is designed around it. Cardiac rehabilitation principles for the member with heart disease; blood glucose management for the diabetic; modifications by trimester for the pregnant member; joint protection for arthritis; rehabilitation-consistent loading for an injury (in consultation with the physiotherapist). Adaptation requires knowledge: trainers with relevant specialist certification, or referral to someone who has it. A general trainer improvising for a cardiac patient is outside their competence.

WHAT GOOD LOOKS LIKE

- Members with identified conditions receive genuinely, specifically adapted programs.
- Adaptation is genuinely informed by appropriate medical guidance where warranted.
- The connection from screening to adaptation is real and traceable.

COMMON FAILURE MODES

- Standard programs are applied to members with identified conditions as though unadapted.
- Adaptation, if it happens, isn't informed by appropriate medical guidance.
- No traceable connection exists between screening findings and program adaptation.

WORKED EXAMPLE

IN PRACTICE

A 1,300-member fitness centre with a growing number of members with chronic conditions.

BEFORE

Members with conditions received general programmes with informal modifications. A member with heart failure was on a high-intensity interval programme. A pregnant member in her third trimester was doing supine exercises. Trainers had no specialist training.

ACTION	A special populations pathway was created: members with identified conditions are programmed by a trainer with the relevant specialist certification (cardiac, diabetes, pre/postnatal, older adult) or referred to a clinical exercise physiologist; programmes follow condition-specific guidelines; the adaptation is documented; monitoring appropriate to the condition (heart rate, glucose, symptoms) is built in. Two trainers obtained specialist certifications.
AFTER	The Monitor reviewed 15 special population programmes with condition-specific adaptations and monitoring, and the trainers' specialist certifications. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List members with identified conditions and who programmed them.
2. Identify or train specialist-certified trainers.
3. Route every member with a condition to them.
4. Follow condition-specific guidelines.

The most common mistake: A general trainer 'adapting' for a cardiac patient by guess.

SELF-ASSESSMENT QUESTIONS

1. Does a member with an identified health condition receive a program specifically adapted to that condition? — *Real, condition-specific adaptation, not a standard program applied regardless.*
Evidence: Condition-adapted program documentation
2. Is this adaptation genuinely informed by medical guidance where the condition warrants it? — *Real, appropriate medical input, not staff independently determining adaptation beyond their own scope.*
Evidence: Medical guidance documentation
3. Is the connection between screening findings and program adaptation genuinely traceable, not assumed? — *A real, specific, traceable connection, not an assumption that adaptation generally*

happens.

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Adaptation happens for cardiovascular conditions but less consistently for other identified conditions.** — Every genuinely identified condition deserves the same specific, careful adaptation.
- **Medical guidance is sought for major conditions but staff independently adapt for less severe ones without documented input.** — Staff should recognise the real limits of their own scope, seeking guidance whenever genuinely warranted, not only for the most severe cases.
- **Adaptation happens initially but isn't revisited if the condition's status changes.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for genuine, condition-specific program adaptation.
Week 2	Establish a clear process for seeking medical guidance where a condition genuinely warrants it.
Week 3	Build a traceable connection between screening findings and program adaptation.
Ongoing	Revisit adaptation as a member's condition status changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Condition adaptation review	Reviews programs for members with identified conditions for genuine, specific adaptation.
DOCUMENT	Medical guidance review	Reviews evidence of appropriate medical guidance informing adaptation where warranted.
ASK	Traceability interview	Asks staff to trace a specific member's screening finding through to their actual program adaptation.

SUPERVISOR TIPS

- **Ask to trace a specific member's identified condition through to their actual program adaptation.** — A real, traceable example reveals genuine practice, not an assumption of general adaptation.
- **Ask staff where they'd draw the line between adapting independently and seeking medical guidance.** — A specific, thoughtful answer reveals genuine understanding of real scope limits.

EVIDENCE BASE

[23] Exercise for members with chronic health conditions must be individualized and carried out with appropriate consideration of medical guidance, not through a generic program, establishing that for this population, individualization is fundamentally a safety matter, not solely an effectiveness consideration.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

5.4 Rest and Recovery Are Genuinely Built Into the Program

CORE

Program design genuinely includes scheduled rest and recovery, appropriate to the individual's training load — not treated as an optional afterthought the member is left to arrange for themselves, disconnected from the actual program.

In plain terms: Rest and recovery days are written into the programme, matched to the member's training load — not left to the member to 'listen to their body.'

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

Adaptation happens during recovery, not during training. A member who trains hard six days a week without planned rest breaks down: overtraining, injury, illness, burnout. Recovery must be programmed:

rest days, lighter sessions, a deload week, sleep and nutrition guidance. Left to the member, the keen ones skip it and the reluctant ones overuse it. The programme states it; the trainer reinforces it; the review checks adherence and signs of under-recovery.

WHAT GOOD LOOKS LIKE

- Rest and recovery are genuinely, specifically scheduled within the program.
- Scheduling is genuinely appropriate to the individual's actual training load.
- Members genuinely understand why recovery matters, not just told to rest.

COMMON FAILURE MODES

- Recovery is left entirely to the member's own, unguided judgment.
- Recovery scheduling, if present, is generic regardless of individual load.
- Members are told to rest without any real understanding of why it matters.

WORKED EXAMPLE

IN PRACTICE

A 1,500-member fitness centre where programmes listed training days only.

BEFORE

Programmes specified what to do on training days. Rest was implied. Enthusiastic members trained daily. Overtraining symptoms — persistent fatigue, declining performance, recurrent minor injury — were common and unrecognised.

ACTION

The programme template now includes recovery explicitly: rest days per week by training load; a deload week every fourth week; recovery guidance (sleep, nutrition, active recovery). Trainers are taught to recognise under-recovery signs and ask about them at review. Members receive a recovery briefing.

AFTER

The Monitor reviewed 20 programmes with explicit rest and deload scheduling, and review notes with recovery questions. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Look at ten programmes. Are rest days written in?
2. Add rest days and a deload week to the template.
3. Teach trainers the signs of under-recovery.
4. Ask about recovery at every review.

The most common mistake: Programming the training and assuming the rest.

SELF-ASSESSMENT QUESTIONS

1. Does program design genuinely include scheduled rest and recovery, not left to the member to arrange independently? — *Real, specific rest scheduling as part of the program, not an unaddressed gap.*
Evidence: Recovery scheduling documentation

2. Is recovery scheduling genuinely appropriate to this individual's actual training load and recovery capacity? — *Genuine, individual appropriateness, not a generic rest interval applied regardless of load.*
Evidence: N/A — tested directly

3. Are members genuinely educated on why recovery matters, not just told to rest without explanation? — *Real, genuine education on the purpose of recovery, not an instruction without context.*
Evidence: Member recovery education documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Recovery is scheduled for high-intensity training but less consistently for moderate-intensity programs.** — Genuine recovery need exists across intensity levels, not high-intensity training alone.
- **Scheduling exists but isn't adjusted when a member's actual training load changes.** — Recovery scheduling should genuinely track actual changes in demand, not remain fixed from initial design.
- **Members are told to rest on specific days but don't understand the underlying reasoning.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current program design for genuine, specific recovery scheduling.
Week 2	Build recovery scheduling appropriate to individual training load across intensity levels.
Week 3	Develop member education explaining the genuine purpose of recovery scheduling.
Ongoing	Adjust recovery scheduling as a member's actual training load changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Recovery scheduling review	Reviews program documentation for genuine, specific rest and recovery scheduling.
DOCUMENT	Appropriateness review	Reviews whether recovery scheduling is genuinely matched to individual training load.
ASK	Member education interview	Asks a member whether they understand why recovery is built into their program.

SUPERVISOR TIPS

- **Ask to see a specific member's program and confirm recovery is genuinely, specifically scheduled.** — A real, specific example reveals genuine practice, not an assumption recovery is addressed.
- **Ask a member why rest days are included in their program.** — A genuine, informed answer reveals real education, not just an instruction followed without understanding.

EVIDENCE BASE

[24] Rest and recovery are established as an integral, scheduled component of exercise prescription frameworks, necessary to prevent injury and enable genuine physiological adaptation, distinct from recovery treated as an unaddressed matter left to individual member discretion.

[ASF training courses on GMJ Academy →](#)

5.5

Programs Are Actively Reviewed and Adjusted as Fitness Changes

CORE

A member's program is genuinely, actively reviewed and adjusted as their fitness level changes — not designed once and left fixed indefinitely, applying an initial assessment's conclusions to a body that has since genuinely adapted.

In plain terms: Programmes are reviewed and adjusted on a schedule — every 4–8 weeks — as the member's fitness changes, not written once and forgotten.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

A programme that was right in week one is wrong in week twelve: the member is fitter, or has plateaued, or is bored, or has developed a niggle. Review means: a scheduled reassessment (every 4–8 weeks), a comparison to the baseline and goals, a conversation with the member, and an updated programme. Without it, members drift — repeating the same session indefinitely, plateauing, losing motivation, or progressing unsafely on their own. The review schedule is tracked; overdue reviews are chased.

WHAT GOOD LOOKS LIKE

- Programs are genuinely, actively reviewed and adjusted as fitness changes.
- Review happens on a real, defined, proactive schedule.
- Adjustment genuinely reflects the member's

COMMON FAILURE MODES

- Programs remain fixed from initial design, never genuinely revisited.
- Review, if it happens, relies solely on the member raising a concern.
- Adjustments, when made, don't genuinely reflect current fitness level.

current, actual fitness
level.

WORKED EXAMPLE

IN PRACTICE

A 1,200-member fitness centre where programmes were written at induction and rarely revisited.

BEFORE

Members received a programme at induction. Review was available on request. Most members were on their induction programme a year later. Plateau and drop-out were high. Nobody tracked reviews.

ACTION

Every programme has a review date (6 weeks). Reviews include a reassessment of key measures, goal progress, member feedback, and an updated programme. The review schedule is in the system; overdue reviews are flagged and the member contacted. Review completion is a trainer KPI.

AFTER

The Monitor reviewed the review schedule (92% completed on time), 20 review records with updated programmes, and retention data (12-month retention up 18%). Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Count members whose programme is more than three months old.
2. Set a six-week review date on every programme.
3. Flag overdue reviews and contact the member.
4. Make review completion a trainer measure.

The most common mistake: A programme from induction, still in use a year later.

SELF-ASSESSMENT QUESTIONS

1. Is a member's program genuinely, actively reviewed and adjusted as their fitness level changes? — *Real, active review and adjustment, not a program fixed from initial design.*

Evidence: Program review record

2. Does review happen on a genuine, defined schedule, not only when a member happens to raise a concern? — *A real, proactive schedule, not reliance solely on member-initiated review.*

Evidence: Review schedule documentation

3. Does adjustment genuinely reflect the member's actual, current fitness level, not the original assessment? — *Real, current-state adjustment, not conclusions carried forward from an outdated initial assessment.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Review happens for personal training clients but less consistently for members following independent programs.** — Every member's program benefits from genuine review as fitness changes, not personal training clients alone.
- **A review schedule exists but isn't consistently followed when the facility is busy.** — A schedule that lapses under operational pressure doesn't provide the genuine, ongoing benefit it's designed for.
- **Review happens but adjustments are minor, not genuinely reflecting meaningful fitness changes since the original design.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current program review practice for genuine, active adjustment versus fixed design.
Week 2	Establish a defined, proactive review schedule for all members, not personal training clients alone.
Week 3	Train staff on making genuine, meaningful adjustments reflecting current fitness level.
Ongoing	Confirm review schedule adherence, particularly during busy periods.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Review record review	Reviews program review records for genuine, active adjustment over time.
DOCUMENT	Review schedule review	Reviews whether review happens on a defined, proactive schedule.
ASK	Currency interview	Asks staff to confirm a specific member's program reflects their current, not original, fitness level.

SUPERVISOR TIPS

- **Ask when a specific member's program was last genuinely reviewed and what changed.** — A specific, real example reveals genuine, active review, not a fixed initial design.
- **Ask how program review differs for members not receiving personal training.** — This reveals whether genuine review extends beyond personal training clients.

EVIDENCE BASE

[25] Progressive overload requires periodic reassessment and adjustment of exercise prescription, as the body adapts to a given stimulus and a fixed program ceases to provide genuine overload once that adaptation occurs.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Fitness & Wellness Standards — all standards**

Self-assess against these criteria →

← **Standard 4 — Equipment Safety & Facility Environment**

Standard 6 — Member Rights & Informed Consent
→

