AMERICAN BOARD OF SURGICAL ASSISTANTS
11414 West Park Place, Park Place, Suite 202 #626, Milwaukee, Wisconsin 53224
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Recertification Continuing Medical Education Form

Tracking Form

Date	Event	Number of Credits Claimed

I certify that the information contained in this document is true and accurate, to the best of my knowledge. I also understand that any intentional misrepresentation or falsifications will result in immediate and permanent termination of my certification, through the ABSA.

Print your name here:_____***Certification Number:*** _____

Signature:_____***Date:***_____

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