



The American Board of Surgical Assistants
11414 West Park Place, Park Place, Suite 202 #626, Milwaukee, Wisconsin 53224
1-877-617-8345 Fax 1-303-539-9847

Audit - Work Verification form

Surgical Assistant – Certified (SA-C) _____

Certification Number _____

Surgical Assistant Signature _____

- I work for a hospital, Surgicenter, Physicians Office, or Surgical Assistant Group (your supervisor will complete the form below).
- I am self-employed (your supervisor at the facility where you work can complete the form below or you can submit billing summaries with the Surgical Assistant modifier code).

Supervisor will complete the below information

- Yes, the Surgical Assistant – Certified (SA-C) listed above has completed 400 cases or 1500 hours in the role of a first assistant in the last two years.
- No, the Surgical Assistant – Certified (SA-C) listed above has NOT completed 400 cases or 1500 hours in the role of a first assistant in the last two years.

Name, Address, and Telephone Number with the extension of the Hospital, Surgicenter, Physician’s Office, or Surgical Assistant Group:

Name of Facility: _____

Address: _____

Telephone: _____

Email Address: _____

Name of Supervisor: _____

Title of Supervisor: _____

I certify, to the best of my knowledge, that the above is true and correct.

Supervisor’s Signature: _____

Date: _____

Note to SA-C: *This document, when completed, is to be scanned or a picture taken, and returned to office@absa.net*

If the requested information is not received by September 30 of this year, your certification will become inactive, and you will need to retake the exam to maintain it.

ABSAs will not close your audit until this form is completed and verified.