



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

Surgical Assistant – Certified (SA-C) _____

Certification Number _____

Surgical Assistant Signature _____

1. The Surgical Assistant – Certified (SA-C) mentioned above has completed 400 cases or 1,500 hours in the role of a **first surgical assistant** within the last two years. ____ **Yes** ____ **No**
(if no, please complete #2)

2. If fewer than the required number of cases or hours, please list the number here with a brief explanation: _____

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

Name: _____

Address: _____

Telephone: _____

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 and submitted with your Digital Recertification Application. Please submit this form along with your Continuing Medical Education and BLS, CPR, ACLS or PALS certification.*