ASSOCIATION OF SURGICAL TECHNOLOGISTS

Surgical Mission Verification Form

Name: ____________________________________________

AST Membership Number: __________ Certification Number: ______________

Date(s) of Surgical Mission: _____________________________________________

Location/Country of Surgical Mission: ______________________________________

Name of Sponsoring Organization: _________________________________________

Team Leader Name: _____________________________________________________

Brief Narrative of Surgical Mission (services provided; type of surgical procedures; your role)

Note: This is not required to be an in-depth report, but rather a brief review of the type of surgical procedures and other services provided to the local population as well as your role on the team, e.g. first scrub, surgical assistant, etc.

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Your Signature ___________________________ Date ______________

Signature of Team Leader ___________________________ Date ______________