



# The American Board of Surgical Assistants

P.O. Box 460604, Aurora, Colorado 80046-0604  
1-303-617-8345 or 1-877-617-8345 Fax: 1-303-539-9847

## 2009 ABSA Certification Examination Application Form

Fields with a *Red* asterisk requires your input. You can use the Tab Button to navigate the fields.

*This form must be filled out on the computer **NOT** printed and handwritten.*

### Personal Information

*Last Name:		*First Name:		Middle Initial:
*Address:			Apt or Bldg Number:	N/A <input type="checkbox"/>
*City:	*State:	*Zip Code:	*Country: (i.e. USA)	
*Home Telephone:			Cell:	
Work Telephone:			Fax:	
*National ID Number:		*Enter Number:		
*Date of Birth:	*Age:	*Sex: M <input type="checkbox"/> F <input type="checkbox"/>	*Marital Status:	
*Place of Birth: (City)			*Country: (i.e. USA)	
Email:			*Occupation:	

### \* Your Training Program

Enter the complete name of your <b>Medical School</b> and date of graduation.	
	Graduation Date:
or	
Enter the complete name of your <b>"ABSA Approved"</b> Surgical Assistant Training Program and date of graduation.	
Note: Basic Nursing and/or Surgical Technology programs <i>Do Not Qualify</i> as surgical assistant training programs.	
	Graduation Date:

### \* Requested Test Location

Test Location and Date ( Check the Examination Facility Locations on our web at: <a href="http://www.absa.net/schedule.htm">www.absa.net/schedule.htm</a> )	
<input type="checkbox"/> Chicago, Illinois	
<input type="checkbox"/> Dallas, Texas	
<input type="checkbox"/> Houston, Texas	
<input type="checkbox"/> Miami, Florida	
or	
Special Examination ( Prior Special Arrangements and Fees Apply )	
Note: This option is for groups only and is <i>Not Available</i> to individuals. Prior authorization is required from Paul F. Weeks, M.D.	
<input type="checkbox"/>	
Approval Code:	(Issued by ABSA Office in Confirmation Letter)

\* Your name, as it should appear on your certificate

Note: We do not place titles on the certificates. (i.e. M.D., PA-C, RN etc.)

### \* Fee Schedule

Fee: \_\_\_\_\_ Check or Money Order Number: \_\_\_\_\_ (No personal checks)

Paid on the ABSA web site through PayPal at [www.absa.net/fee.htm](http://www.absa.net/fee.htm)

Note: If paid through PayPal you must include a copy of your PayPal confirmation receipt

### Checklist of Required Documentations to be submitted with Application (Do not send original documents & Keep copies for your records)

#### Physicians (U.S. or Foreign Trained)

- Provide a notarized copy or translated copy of Medical School Graduation. The Medical School must be listed in the *International Medical Education Directory* (IMED). (The IMED lists recognized U.S. and foreign medical schools. <http://imed.ecfmq.org>)
- Successful completion of TOEFL or equivalent exam and/or coursework, documenting English proficiency.
- Provide a notarized copy or translated copy of Residency and/or Advanced Training.
- Provide a copy of Curriculum Vitae (Resume).
- If TOEFL: **Internet-Based** = 88-89 or greater, **Computer-Based** = 230 or greater, **Paper-Based** = 570-573 or greater  
The above-required items **must document** a minimum of two years primary or advanced surgical experience

or

- Provide documentation of having first assisted, for a minimum of two years.
- Provide documentation of having **first assisted** on at least **400** clinical surgical cases or **1500** clinical surgical hours, during the last two years, where you were listed as the first assistant, on the operative record. (**Case Log or Computer Printout required**)

#### Licensed and Non-licensed Allied Health Professionals

PA's, RN's, LPN's, CST's and ST's must provide documentation of successful completion of an ABSA approved or CAAHEP approved formal surgical assistant training program. You must also include an Official Transcript, documenting successful completion of the required college-level courses listed in the Eligibility Requirements Section on our website at: [www.absa.net](http://www.absa.net).

### Signature Section

(Print completed form; then Sign & Date)

I certify that the information contained in this application is true and correct. I understand that any misrepresentation will result in rejection of this application and/or revocation of any certification obtained through the ABSA. I agree to hold the American Board of Surgical Assistants free from damage or complaint, by reason of any action its directors, officers or agents may take in connection with this application, or failure of the ABSA to issue certification to me.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please mail all forms, documentation and appropriate fees (cashier's check, money order or PayPal receipt) to:

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P.O. Box 460604  
Aurora, Colorado 80046-0604

Print Form

Reset Form