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**