

SANE Certification Renewal Application

<u>Please note that all information may be subject to disclosure under</u> <u>the Texas Public Information Act.</u>

Type of Application (Check all that apply)

□ Adult SANE Certification (CA-SANE) □ Pediatric SANE Certification (CP-SANE)

Applicant's Information

Applicant Name (as it appears on RN license)			Work Phone Number		
Mailing Address			Alternate Phone Number (Optional)		
City		State			Zip Code
RN License Number and SANE Certification N Issuing State		Number	Email Addr	ess	

Location of SANE Practice

Name of Primary Facility		Facility Phone Number		
Facility Mailing Address (if different from above)	County	City	State	

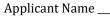
SANE Coordinator Information

SANE Coordinator's Name	SANE Coordinator's Phone Number	SANE Coordinator's Email

Medical Director Information

Medical Director's Name	Medical Director's Phone Number	Medical Director's Email

Office of the Attorney General, Crime Victim Services Division, SAPCS SANE Program Post Office Box 12548, MC 011-1 • Austin, TX 78711-2548 Fax: (512) 370-9801 • sapcs@texasattorneygeneral.gov





SANE Renewal Verification Form

Applicant Verification

I, _________(print name), verify that all minimum requirements for SANE Certification have been completed as required by the OAG. I verify that all information provided in this application and other supporting documentation is true and correct to the best of my knowledge. I authorize any organization or individual who has information relating to my application to release it to the OAG as needed to process this application. I understand that the OAG or any agent or representative of the office, has the right to review, investigate and verify the information provided. I understand it is my own responsibility to maintain all documents (including copies of this application). It is not the responsibility of the OAG to maintain my documentation on my behalf. I must maintain my documentation as I may be subject to audit at any time. I understand and agree that if false, misleading, or intentionally incomplete information is provided my application may be denied, could result in the revocation of my SANE certification, or I may be subject to any other penalties authorized by law.

Applicant's Signature

Date



SANE Continuing Education Activities Form

Applicants selected for audit must be able to provide proof of continuing education activities such as training certificates, agendas, and objectives. If these documents are not available when requested, the submitted hours may be denied.

Please list all presentations separately.

	Activity Name				
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SANE Case Review Form

Applicants selected for audit must be able to provide proof of case review activities such as certificates of attendance or other proof of attendance. If these documents are not available when requested, the submitted hours may be denied.

Case Review	Case Review Provider					
Case	Date and Location	Time Spent on Adult	Time spent on Adolescent	Time spent on Prepubescent		
Case Review	Case Review Provider					
Case	Date and Location	Time Spent on Adult	Time spent on Adolescent	Time spent on Prepubescent		
Case Review	Case Review Provider					
Case	Date and Location	Time Spent on Adult	Time spent on Adolescent	Time spent on Prepubescent		
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SANE Renewal Clinical Requirement Form

I, _____ (print name), have completed the following number of medical forensic sexual assault

examinations within the time frame of my current certification period of ______:

- _____ prepubescent patient
- _____ adolescent patient
- _____ adult patient (young, middle-aged, or elder)

I understand that the Office of the Attorney General may request additional information from me. I understand and agree that providing false, misleading, or intentionally incomplete information can result in the denial of my application or the revocation of my SANE certification.

Applicant's Signature

Date