SANE Certification Renewal Application

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

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 Issuing State	SANE Certification Number	Email Address	

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

Applicant Name _____

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**

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Applicant Name _____

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	Activity Name			
	Date	Activity Provider	Location	Number of Hours
Activity	Activity Name			
	Date	Activity Provider	Location	Number of Hours
Activity	Activity Name			
	Date	Activity Provider	Location	Number of Hours
Activity	Activity Name			
	Date	Activity Provider	Location	Number of Hours
Activity	Activity Name			
	Date	Activity Provider	Location	Number of Hours

Applicant Name _____

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Activity	Activity Name			
	Date	Activity Provider	Location	Number of Hours
Activity	Activity Name			
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Activity	Activity Name			
	Date	Activity Provider	Location	Number of Hours

Applicant Name ____________________

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			
	Date and Location	Time Spent on Adult	Time spent on Adolescent	Time spent on Prepubescent
Case Review	Case Review Provider			
	Date and Location	Time Spent on Adult	Time spent on Adolescent	Time spent on Prepubescent
Case Review	Case Review Provider			
	Date and Location	Time Spent on Adult	Time spent on Adolescent	Time spent on Prepubescent
Case Review	Case Review Provider			
	Date and Location	Time Spent on Adult	Time spent on Adolescent	Time spent on Prepubescent
Case Review	Case Review Provider			
	Date and Location	Time Spent on Adult	Time spent on Adolescent	Time spent on Prepubescent

Effective 03/2017

Applicant Name ____________________

SANE Case Review Form

Case Review	Case Review Provider			
	Date and Location	Time Spent on Adult	Time spent on Adolescent	Time spent on Prepubescent
Case Review	Case Review Provider			
	Date and Location	Time Spent on Adult	Time spent on Adolescent	Time spent on Prepubescent
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Case Review	Case Review Provider			
	Date and Location	Time Spent on Adult	Time spent on Adolescent	Time spent on Prepubescent

Effective 03/2017

Applicant Name: _____

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

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