APPLICATION

State of New Hampshire

****

Comprehensive Sexual Assault Nurse ExaminerTraining Program

**Name:** Click here to enter text.

**RN State and License #**: Click here to enter text.

**How long have you been practicing as an RN?** Click here to enter text.

**Home Address:** Click here to enter text.

**Home Telephone:** Click here to enter text.

**Cell phone:** Click here to enter text.

**Work phone:** Click here to enter text.

**Email Address:** Click here to enter text.

**Current Employer:** Click here to enter text.

**Nurse Manager Name:** Click here to enter text.

**Nurse Manager Email:** Click here to enter text.

**Please check and attach these items to this application:**

[ ]  Current resume

**Please answer the following questions to the best of your ability:**

**Please describe your current or past experience in an acute care setting (ie: ICU, ED, Med/Surg) .** Click here to enter text.

**Please describe your current hospital affiliation.** Click here to enter text.

**Is it your intention to practice as a Sexual Assault Nurse Examiner?** Click here to enter text.

**Where?** Click here to enter text.
**On which of the following populations:** [ ] Adolescent/Adult [ ] Prepubescent [ ] Both

**Is your institution supporting you being trained in any way?** Click here to enter text.

**CONDITIONS OF SANE TRAINING APPLICATION**

In requesting admission to the State of New Hampshire Comprehensive Sexual Assault Nurse Examiner (SANE) Training program, I agree to each of the following provisions:

1. I affirm that the information submitted by me in this application is true to the best of my knowledge and belief, and is furnished in good faith.

2. I intend to practice in the role of a SANE and I commit to the following terms of the Program:

 a. I will assume responsibility for submitting my license number so that the program may verify my nursing license as active and unrestricted;

 b. I will comply with all Currency of Practice requirements as stated in the most up-to-date version of the Currency of Practice Guidelines;

 c. I will comply with the SANE data reporting requirements in a timely manner; and

 d. I will provide the NH SANE Program with any paperwork needed that shows my currency of practice is up to date.

**Name:** Click here to enter text. **Electronic Signature:** Click here to enter text.

**Date:**

Please return both pages of this application and any additional items to:

Madison Lightfoot

## State of New Hampshire

**SANE PROGRAM**

**NHCADSV**

**PO Box 353**

**Concord, NH 03302**