

INSTRUCTIONS FOR THE SANE APPLICATION FOR CREDENTIAL

FAX COPIES OF APPLICATIONS WILL NOT BE ACCEPTED BY KBN

General Information PLEASE PRINT CLEARLY IN BLACK INK

- Licensure fees and regulatory requirements are subject to change. Fees are NON-REFUNDABLE:

Initial - \$120 Reinstatement - \$120

- Send to the Kentucky State Police (KSP):

1. Completed fingerprint card (see enclosed fingerprint instruction sheet)
2. Check or money order in the amount of \$12.00, payable to KSP. Send to:
Kentucky State Police
Records Division
1266 Louisville Rd.
Frankfort, KY 40601

Validation of name change(s) is required if the name on any document received at KBN is different from the name on the application for licensure. Acceptable validations include a copy of either a:

1. Social security card,
2. Marriage license, **OR**
3. Court order or divorce decree showing the right to a name change.

You are required to notify KBN within 30 days of an address change. The notification shall include:

1. Name
2. Social security number or Kentucky nursing license number
3. New address

The application is valid for one year from the date received at KBN.

Practicing without a permanent Kentucky SANE credential may subject you to disciplinary action by KBN.

It is your responsibility to assure that all documents have been received **BEFORE** the application for SANE credential expires.

Section 1: Biographical Data

- All information shall be provided.

KBN does not distribute/provide email addresses to third parties.

Section 2: Method of Application

- Mark the appropriate method of application:
 - **Initial:** You have never held a Kentucky SANE credential.
 - **Reinstatement:** Your Kentucky SANE credential lapsed, and you want an active SANE credential.

Section 3: Registered Nurse Licensure Information

- Submit a copy of your current compact RN license.

Provide the state of your compact RN license.

Provide the expiration date of your compact RN license.

Section 4: SANE Educational Program Information

- List the name of the approved SANE program you attended.
Submit verification of completion of SANE program (copies of certificates of completion).

Section 5: Nursing Practice and Primary Residence

- Indicate your primary state of residence.
Indicate if you are practicing ONLY in a military/federal facility.
Select all jurisdictions in which you currently practice.
Evidence of primary residence includes:

- voter registration,
- driver's license,
- Federal income tax return and/or
- Military Form No. 2058.

DO NOT submit evidence of primary residence unless requested to do so.

Section 6: Disciplinary

- All questions shall be answered. If you answer "yes" to any of these questions, your application will not be processed until the following documents are received:
 1. A detailed letter of explanation for each action taken.
 2. A certified copy of the Board's or other licensing agency's action.

Failure to report any action pending or disciplinary action **EVER** taken on a nursing license or other professional license may subject you to disciplinary action.

Failure to report participation in an alternative to discipline/diversion program may subject you to disciplinary action.

Section 7: Criminal History

- All questions shall be answered. You **SHALL REPORT** the following and submit the required documents:
 1. All felony convictions ever received (submit Certified Court Documents & Detailed Letter of Explanation)
 2. All misdemeanor(s), including DUIs, received WITHIN 5 years of the date of application (submit Certified Court Documents & Detailed Letter of Explanation)
 3. All misdemeanor(s), including DUIs, received PRIOR TO 5 years of the date of application (SHALL REPORT, but no documents required)

NOTE: Traffic violations OTHER than DUIs do not need to be reported.

If you answered "**YES**" to any question(s), allow 3 months for all information to be reviewed by KBN.

Failure to report any criminal convictions **EVER** received may subject you to disciplinary action.

Section 8: Reinstatement of a SANE Credential

Return to KBN:

Completed application

Fee of \$120

Kentucky Criminal History Report, obtained by the Administrative Office of the Courts

Proof of earning at last 5 hours of continuing education in domestic violence or forensic nursing

Section 8: Reinstatement of a SANE Credential (Continued)

Send to the Kentucky State Police:

- Completed fingerprint card (see enclosed fingerprint instruction sheet)
- Check or money order in the amount of \$12.00, payable to KSP. Send to:
Kentucky State Police
Records Division
1266 Louisville Rd.
Frankfort, KY 40601

NOTE: If the SANE credential has been expired for more than four (4) consecutive license periods, you shall provide evidence of completion of a SANE educational program. The course shall be completed during the period your SANE credential lapsed.

Section 9: Responsibility & Accountability of KY Licensed Nurses

- Please read carefully before signing this application.

Falsification of any information contained herein may be cause for disciplinary action by KBN.

The portion of nursing law cited in this section relating to KRS 314.021 explains the accountability and responsibility of all nurses licensed to practice nursing in Kentucky.

All licensed nurses practicing in Kentucky shall adhere to the Kentucky Nursing Laws and regulations, which are available at <http://kbn.ky.gov/legalopinions/Pages/laws.aspx>.

It is a violation of Kentucky Nursing Law to practice as a Sexual Assault Nurse Examiner (SANE) nurse with an expired RN license, and/or SANE credential.

SEXUAL ASSAULT NURSE EXAMINER APPLICATION FOR CREDENTIAL

Office Use Only

APPLICATION FEE IS NON-REFUNDABLE AND SUBJECT TO CHANGE
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Section 1: Biographical Data

_____ / _____ / _____
Last Name (print clearly)

First Name (print clearly)

_____ Male Female
Middle Name (print clearly)

____ - ____ - ____ / ____ / ____
Social Security # (print clearly) **Date of Birth** **U.S. Citizen?** Yes No

Address (print clearly)

_____ - _____
City (print clearly) **State** **Zip Code** (print clearly)

County of Residence (print clearly) **Ethnic Group:**
 African American Native American
 Asian Pacific Islander
 Multiracial Caucasian
 Hispanic or Latino/a Other

International Country (not USA) (print clearly)

____ - ____ - ____
International Postal Code (print clearly)

____ - ____ - ____
Daytime Phone Number (print clearly) **Home Phone Number** (print clearly)

Email Address (print clearly)

Section 2: Method of Application

<u>If You Have Never Held a KY SANE Credential</u>	<u>Fee</u>	<u>Complete These Sections</u>	<u>Submit</u>
<input type="checkbox"/> Initial (S1):	\$120 Fee	1, 2, 3, 4, 5, 6, 7, 9, 10	Kentucky Criminal History Report
<u>If You Held a KY SANE Credential</u>	<u>Fee</u>	<u>Complete These Sections</u>	<u>Submit</u>
<input type="checkbox"/> Reinstatement (S3):	\$120 Fee	1, 2, 3, 5, 6, 7, 8, 9, 10	Kentucky Criminal History Report

Section 3: Registered Nurse Licensure Information

You shall hold a current RN license from Kentucky or a compact state before a SANE credential will be issued. Submit a copy of your current compact license with this application.

_____ / _____ / _____
State of Current Compact RN Licensure **Compact RN License #** (print clearly) **Expiration Date (MM/DD/YYYY)**

Section 4: SANE Educational Program Information

Please answer the following questions about the SANE program you attended.

Name (print clearly)

_____ / _____
City (print clearly)

_____ / _____
State Month & Year Completed

You shall include proof of completion of:

1) A KBN-approved SANE educational program, and 2) the required didactic instruction and clinical practice.

If the course you attended was not located in Kentucky, you shall also show proof of having completed continuing education hours specific to Kentucky legal, forensic, and rape crisis issues. Contact KBN for specific information on out of state programs.

Section 5: Nursing Practice and Primary Residence

Indicate Your Primary State of Residence: KY Other: _____ Do you practice nursing ONLY in a military/federal facility? Yes No

DO NOT SUBMIT EVIDENCE OF PRIMARY RESIDENCE UNLESS REQUESTED TO DO SO.

Check the box for EACH state in which you currently practice:

<input type="checkbox"/> AL	<input type="checkbox"/> AZ	<input type="checkbox"/> DC	<input type="checkbox"/> GU	<input type="checkbox"/> IL	<input type="checkbox"/> LA	<input type="checkbox"/> MI	<input type="checkbox"/> MT	<input type="checkbox"/> NH	<input type="checkbox"/> NY	<input type="checkbox"/> PA	<input type="checkbox"/> SD	<input type="checkbox"/> VA	<input type="checkbox"/> WI
<input type="checkbox"/> AK	<input type="checkbox"/> CA	<input type="checkbox"/> DE	<input type="checkbox"/> HI	<input type="checkbox"/> IN	<input type="checkbox"/> MA	<input type="checkbox"/> MN	<input type="checkbox"/> NC	<input type="checkbox"/> NJ	<input type="checkbox"/> OH	<input type="checkbox"/> PR	<input type="checkbox"/> TN	<input type="checkbox"/> VI	<input type="checkbox"/> WV
<input type="checkbox"/> AR	<input type="checkbox"/> CO	<input type="checkbox"/> FL	<input type="checkbox"/> IA	<input type="checkbox"/> KS	<input type="checkbox"/> MD	<input type="checkbox"/> MO	<input type="checkbox"/> ND	<input type="checkbox"/> NM	<input type="checkbox"/> OK	<input type="checkbox"/> RI	<input type="checkbox"/> TX	<input type="checkbox"/> VT	<input type="checkbox"/> WY
<input type="checkbox"/> AS	<input type="checkbox"/> CT	<input type="checkbox"/> GA	<input type="checkbox"/> ID	<input type="checkbox"/> KY	<input type="checkbox"/> ME	<input type="checkbox"/> MS	<input type="checkbox"/> NE	<input type="checkbox"/> NV	<input type="checkbox"/> OR	<input type="checkbox"/> SC	<input type="checkbox"/> UT	<input type="checkbox"/> WA	

Section 6: Disciplinary

If you answer "yes" to any of these questions, you **SHALL** provide the following documents as indicated below:

1. A detailed letter of explanation for each action taken.
2. A certified copy of the Board's or other licensing agency's action.
3. If you have more than two disciplinary events, please list the event and state and year received on a separate piece of paper. Mail all documentation to the KBN address.

Check the appropriate boxes and fill out information for each "yes" answer: **If yes, list STATE and YEAR** **If yes, list STATE and YEAR**

Have you ever been denied a nursing license in any state (for reasons other than failure to pass State Board Exam/NCLEX)? Yes No State: _____ Year: _____ State: _____ Year: _____

Do you have a current investigation, disciplinary action or a complaint pending on your nursing license, other professional license/certification or your privilege to practice in any state(s)? Yes No State: _____ Year: _____ State: _____ Year: _____

Are you currently a participant in a state board/designee monitoring program including alternative to discipline, diversion, or a peer assistance program? Yes No State: _____ Year: _____ State: _____ Year: _____

Has any licensing or regulatory authority in any U.S. state or jurisdiction EVER denied, limited, suspended, probated, revoked, or otherwise disciplined a nursing or other professional or occupational license, certificate or multi-state privilege to practice that you held? Yes No State: _____ Year: _____ State: _____ Year: _____
Yes, type of license(s)/certification(s): _____

Section 10: Attestation Statement

I certify that I am the person referred to in the foregoing application for Sexual Assault Nurse Examiner in Kentucky; that I am not in default of a student loan or I am in repayment status of a student loan administered by the Kentucky Higher Education Assistance Authority (KHEAA), that I am not delinquent in the repayment of a defaulted Nursing Incentive Scholarship Fund award administered by KBN, that all statements contained herein and on all attachments are true and correct in every respect; and that I have read and understand this application and all requirements stated therein. I further understand that all information on this application is subject to an audit for verification and that the falsification of any information contained herein will be cause for disciplinary action. I declare my primary state of residence to be the state as indicated in Section 5 of this application.

Applicant's Signature

_____ / _____ / _____

Date