IOWA DEPARTMENT OF JUSTICE
Reapproval for Sexual Assault Nurse Examiners and Qualified Providers

Instructions (DO NOT SUBMIT THIS PAGE WITH APPLICATION FOR RENEWAL):

The following are the requirements for renewal of the Sexual Assault Nurse Examiner and Qualified Provider status at the Iowa Attorney General's Office. All forms must be filled out completely and accurately. Applicants who do not submit a complete application or who have not completed all the requirements prior to submission will not be considered for renewal. Failure to do so will result in your name being removed from the qualified provider list and you will not be eligible for reimbursement/payment. Applicants will be provided written notification if the application is incomplete. Applicants who receive this notification may contact the Sexual Assault Forensic Response Coordinator at the Iowa Attorney General's Office for more information on providing the missing information.

REQUIREMENTS:

- A minimum of 150 hours of intended direct care of sexual assault patients. The 150 hours are not 150 hours of sexual assault forensic examinations. On-call hours, and working a scheduled shift also qualify if the qualified provider is available and willing to perform exams. All on-call hours will qualify towards the minimum of 150 hours. The SANE Coordinator, Facility Supervisor and/or Medical Director must sign off on the application.

- All qualified providers shall obtain 50 hours of education related to sexual assault every three years. Topics can include: Trauma, Assessment and Documentation, Evidence Collection, Patient Management, Legal Issues and the Judicial Process, and Professional Practice. Proof of attendance must be recorded on the form below. For IAFN Certified SANEs, the Sexual Assault Forensic Response Coordinator may also accept a new passing score on the IAFN certification exam every three years in lieu of the 50 education hours.

- Qualified providers must attend *at least* one virtual or in-person biannual meeting led by the Sexual Assault Forensic Response Coordinator.

- Verification of number of sexual assault forensic examinations. If a qualified provider does not complete at least two examinations every 16 months, then the qualified provider shall attend an approved clinical simulation training or work with a designated preceptor to validate their skills. The Sexual Assault Forensic Response Coordinator will maintain a list of approved clinical simulation trainings and approved preceptors in Iowa. For a preceptor to be approved to validate skills, he or she shall have a minimum of one year as a qualified provider and have completed a minimum of ten sexual assault forensic examinations.

Submit the ***complete*** application packet via:
1. Email: SAEProvider@ag.iowa.gov
2. Fax: (515) 281-8199
3. Mail: Iowa Attorney General's Office
Victim Assistance Section, Attn: SAFR Coordinator
Hoover Building, 1305 E. Walnut St, Des Moines, IA 50319

AG Staff Only:

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Please type or write legibly. Any questions should be directed to the Sexual Assault Response Coordinator at the Iowa Attorney General's Office at 515-281-5044 or SAEProvider@ag.iowa.gov. Reapproval is due to the Sexual Assault Forensic Response Coordinator by March 31 every three years from the last date of approval. All documentation shall be submitted no later than March 31st. This form shall be submitted every 3 years with re-approval.

Training Log for (check one):

☐ Adult/Adolescent SANE ☐ Pediatric SANE ☐ M.D. / D.O.

Date of didactic course completion: ________________

First Name:__________________________ Last Name: ___________________________ Date: ___________________

Direct Care Hours:

A minimum of 150 hours of intended direct care of sexual assault patients is required.

Practice: ☐ Hospital based ☐ Community Based ☐ CPC/CAC

Direct Care Hours (choose one): ☐ On-Call ☐ Normal Work Hours ☐ Combination of Both

SANE Coordinator/ Facility Supervisor Verification:

I, ___________________________, the SANE Coordinator/Facility Supervisor for __________________________ (*name of applicant)* hereby certify, to the best of my knowledge, the provided information is true and accurate. I certify __________________________ (*name of applicant*) has completed the mandatory requirements of at least 150 hours of intended direct care for sexual assault patients through on-call or within the duties of their position, or a combination of both.

Printed Name and Title: ____

Signature: ____ **Date:** ________________________________

Phone: _______________________________ **Email:** ____

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Continuing Education Activities:

Applicants 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. Attach additional pages, if needed.

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			
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Continuing Education Activities Continued:

Applicants 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. Attach additional pages, if needed.

Please list all presentations separately.

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Virtual or In-Person Meeting Led by Sexual Assault Forensic Response Coordinator:

Must attend at least one virtual or in-person biannual meeting led by the Sexual Assault Forensic Response Coordinator.

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

Clinical Skills Requirement Form:

A qualified provider must complete at least two examinations every 16-months on either actual or mock patients.

I, ____________________ (*print name*), have completed the following number of medical forensic sexual assault examinations within the time frame of my current certification period of ______________________________________:

_______ Pediatric (0-11) _______ Adolescent (12-17) _______ Adult patient (18+)

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11.2024

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Applicant Verification

I, ______________________________________ (print name), verify that all minimum requirements for Sexual Assault Nurse Examiner or Qualified Provider status have been completed as required by the Iowa Attorney General's Office. A ll the 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 Iowa Attorney General's Office as needed to process this application. I understand that the Iowa Attorney General's Office 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 Iowa Attorney General's Office 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 Qualified Provider status, or I may be subject to any other penalties authorized by law.

Printed Name and Title: ____

Signature: ____ **Date:** _____________________________

Phone: ____________________________ **Email:** ____

AG Staff Only:

Date received: ____________ Date Approved: ______________ Date Denied: ______________ Initials: _________