Stormont Vail Health

Stormont Vail Health

SANE – Sexual Assault Nurse Examiner

2025 Date: June 23

Please Print

Name_____

Email_____

Title: ___ APRN ____ RN ___ Physician ___

Professional License # _____ State: _____

Mailing Address: _____

SVH employee: ___ Yes ___ No If yes, indicate department_____

Employed in Kansas _____ YES _____ NO Employer Name, if not SVH _____

Payment Information (Prepayment required for course registration)

Registration Deadline: One Week Prior to Course Date

Registration Fee: Kansas-employed Nurses – **FREE** **$300.00 Non-Kansas employed Nurses**

____ **INVOICE** **(an invoice will only be sent if marked) please indicate billing information below:**

_____

_____

_____ Checks payable to Stormont Vail Health, mail to:

Clinical Education
1500 SW 10th Ave, Topeka KS 66604
Attn: Kathy Watson
OR
email to: dwatson@stormontvail.org

If your check is returned for any reason, there is a $30 charge.

Visa ____ MasterCard ____ Discover ____ American Express ____

Card #_____ Exp. Date ___ /___ Security Code (on back) _____

Billing Address of Card _____

Cardholder Signature _____

Questions? Contact (785) 354-5321 Fax Registration to: (785) 354-5286 attn: Kathy Watson