



SANE — Sexual Assault Nurse Examiner

2026 Dates: March 9-13 _____

Please Print

Name _____

Email _____

Title: APRN RN Physician Assistant Physician Paramedic

Professional License # _____ State: _____

Mailing Address: _____

SVH employee: Yes No If yes, indicate department _____

Employed in Kansas YES NO

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