

**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 10<sup>th</sup> Ave, Topeka KS 66604**  
**Attn: Kathy Watson**  
OR  
email to: [dwatson@stormontvail.org](mailto: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