New York Sexual Assault Forensic Examiner (NYSAFE): Certification Application

Certification may be processed using this form for any registered nurse, nurse practitioner, physician assistant, or physician providing sexual assault medical forensic examinations.

Applications will only be accepted if the information marked with an asterisk is complete and all signatures are provided. If the application cannot be processed for any reason, you will be notified. Upon approval, you will receive a letter via email to serve as proof of valid certification for a period of three years. You may be subsequently audited for more information. The Department will email you an application to renew your certification approximately four months before your next registration expires. It is your responsibility to notify this office of any application information changes. Complete applications or questions can be submitted to rcprpt@health.ny.gov.

Applicant Information

*Full Name: _____
Last *First*

*Home Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

*Primary Phone: _____ *Primary E-mail: _____

Secondary Phone: _____ Secondary E-mail: _____

*Affiliated Hospitals or other institutions: _____

*Is this your first time applying to become a NYSAFE? ☐ Yes ☐ No

If no, when was your last NYSAFE certification? _____

The 'Sexual Assault Examiners' listserv is a peer-support group for sharing information and advertising upcoming meeting and training opportunities across the State. If you are interested in joining, please contact dcjsvawa@dcjs.ny.gov.

Applicant Type

☐ Registered Nurse ☐ Nurse Practitioner ☐ Physician Assistant ☐ Physician

*License No.: _____

International Association of Forensic Nurses (IAFN) Certification

☐ IAFN SANE-A Date: _____ ☐ IAFN SANE-P Date: _____

Professional Licensure Attestation

I attest, under penalty of perjury, that I am currently qualified, and registered and licensed, to practice in the State of New York within the statutory scope of the professional licensure designated above. I understand that it is my responsibility to provide all supporting documentation necessary for the verification of my New York State (NYS) professional license, should it be requested by the Department. I understand I am solely responsible for ensuring that any change in status to my NYS professional license is reported to the Department and any appropriate governing body pursuant to current NYS Statute and Regulation. I understand that failure to comply with the aforementioned may result in revocation of my NYSAFE certification.

Applicant Signature: _____ Date: _____

Clinical Experience Attestation

I attest, under penalty of perjury, that I have a minimum of one-year, full-time clinical post-graduate experience in the professional license area designated above. I understand that it is my responsibility to provide all supporting documentation necessary for the verification of my experience, should it be requested by the Department. I understand that failure to comply with the aforementioned may result in revocation of my NYSAFE certification.

Applicant Signature: _____ Date: _____

Physician Providing Medical Oversight Attestation

I attest, under penalty of perjury, that I will provide qualified medical oversight to the above-named applicant.

Physician Name and Title: _____

Physician Signature: _____ Date: _____

Applicants who are licensed to practice as a nurse practitioner or physician are exempt from this requirement.

Training Course Attestation

I attest, under penalty of perjury, that I have successfully completed at least 40 hours of didactic and clinical training related to the care of sexual assault patients at a training program that has been approved by the Department. A list of approved programs can be found on the Department's website. I understand that it is my responsibility to provide all supporting documentation necessary for the verification of my training, should it be requested by the Department. I understand that failure to comply with the aforementioned may result in revocation of my NYSAFE certification.

Training Course: _____ Date Completed: _____

Applicant Signature: _____ Date: _____

Applicants who can demonstrate competence in some or all course objectives required by the Department may be eligible for exemption from those components of the course. If you received at least 40 hours of didactic and clinical training related to the care of sexual assault patients at a training program that has not been approved by the Department, leave this signature blank and submit the 'Training Course Exemption Attestation'.

Preceptorship Attestation

I attest, under penalty of perjury, that the above-named applicant has successfully completed a competency-based post-course preceptorship. This applicant has demonstrated competency in providing sexual assault medical forensic exams. I understand that it is my responsibility to provide all supporting documentation necessary for the verification of the applicants' training to the applicant. I will notify the applicant that it is their responsibility to provide such documentation, should it be requested by the Department, and that failure to comply with the aforementioned may result in revocation of their NYSAFE certification.

Preceptor Name and Title: _____ Date Complete: _____

Preceptor Signature: _____ Date: _____

Applicants may opt out of this attestation and provide proof of a competency-based post-course preceptorship in the form of an attachment.