MA SANE Application

MA Sexual Assault Nurse Examiner Program
Phone: 617-624-5425

Date:

Name:

Address:

State/Province:

Zip/Postal Code:

Phone:

Email:

Have you ever worked for the Commonwealth of MA before?

Please check the region you would like to provide SANE services. You must be able to respond to each hospital in the region within 60 minutes of being paged.

- ◯ **Western MA:** Baystate Medical Center, Berkshire Medical Center, Cooley Dickinson Hospital, Mercy Medical Center, UMASS Amherst University Health Services and Baystate Wing Memorial Hospital
- ◯ **Central MA:** Harrington Memorial Hospital, Milford Regional Medical Center, St. Vincent's Hospital, UMASS Memorial Hospital and UMASS University Hospital
- ◯ **Northeastern MA:** Lawrence General Hospital and Lowell General Hospital
- ◯ **Boston MA:** Boston Medical Center, Brigham and Women's Hospital, Beth Israel Deaconess Hospital, Cambridge Hospital, Children's Hospital Boston, Massachusetts General Hospital and Newton Wellesley Hospital
- ◯ **Southeastern MA:** Beth Israel Deaconess - Plymouth (Jordan), Brockton Hospital, Charlton Memorial Hospital, Morton Medical Center, South Shore Hospital, St. Luke's Hospital and Tobey Hospital
- ◯ **Cape / Islands:** Cape Cod Hospital and Falmouth Hospital

Education

Name of School and Complete Mailing Address	Dates Attended	Major or Degree

How long have you been practicing as a RN?

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Professional Licensure

1. Has your nursing license ever been limited, suspended, revoked, denied or subjected to probationary conditions in any jurisdiction? ☐ NO ☐ YES

2. Have your privileges at any hospital ever been suspended, diminished, revoked or denied renewal? ☐ NO ☐ YES

3. Have you ever voluntarily relinquished your Allied Health Professional staff membership, clinical responsibilities, professional society membership or professional license? ☐ NO ☐ YES

If the answer to any of the above is YES, please explain:

Professional Liability Information

1. Have any professional liability suits been filed against you which are pending adjudication? ☐ NO ☐ YES

2. Have any judgements or settlements been made against you in a professional liability suit case within the past 10 years? ☐ NO ☐ YES

If the answer to any of the above is YES, please explain:

Please note that professional liability insurance is required for all SANE program practitioners.

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Voluntary Self-Identification

We invite you to complete the self-identification information below. This is being requested on a voluntary basis. You will not be subjected to adverse treatment either by providing the information or by declining to complete these sections.

What is your gender?

- ☐ Male
- ☐ Female
- ☐ Nonbinary
- ☐ I choose not to self-Identify

What is your race / ethnicity?

- ☐ **Hispanic or Latino**

  A person of Mexican, Puerto Rican, Cuban, Central or South America, or other Spanish culture or origin, regardless of race.

- ☐ **White (Not Hispanic or Latino)**

  A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

- ☐ **Black or African American (Not Hispanic or Latino)**

  A person having origins in any of the Black racial groups of Africa.

- ☐ **Asian (Not Hispanic or Latino)**

  A person having origins in any of the original peoples of Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand and Vietnam.

- ☐ **Native Hawaiian or other Pacific Islanders (Not Hispanic or Latino)**

  A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

- ☐ **American Indian or Alaskan Native (Not Hispanic or Latino)**

  A person having origins in any of the original peoples of North America and South America (including Central America), and who maintains tribal affiliation or community attachment.

- ☐ **Two or More Races**

  A person who identifies with more of one of the above six races.

- ☐ **I choose not to self-identify**

Are you a Veteran?

- ☐ I Identify as a Veteran
- ☐ I am not a Veteran
- ☐ I choose not to Identify

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Employment History (list up to 3) most recent experience first.

1.

Name of Employer:

Name of Supervisor:

Dates of Employment:

From: **To:**

Complete Address:

Phone #:

Job Title:

2.

Name of Employer:

Name of Supervisor:

Dates of Employment:

From: **To:**

Complete Address:

Phone #:

Job Title:

3.

Name of Employer:

Name of Supervisor:

Dates of Employment:

From: **To:**

Complete Address:

Phone #:

Job Title:

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REFERENCES

Please list the 3 references to whom you will be sending the Reference Form. At least 2 of the 3 must be a Registered or Advanced Practice Nurse, and at least 1 must be an immediate supervisor.

Reference # 1 Name

Email

Phone

Reference# 2 Name

Phone

Email

Reference # 3 Name

Phone

Email

Please tell us why you would like to become a SANE / take care of sexual assault patients.

Continue to next page / print and mail

Please print completed application, attach your Resume / CV, and mail to address below:

MA Department of Public Health
SANE PROGRAM
MA SANE Application c/o LaToya Brown
250 Washington St 4th Floor
Boston, MA 02108

Thank you for your interest in the MA SANE program, we will let you know by e-mail when we have received your application.

PLEASE PRINT THIS FORM AND KEEP A COPY FOR YOUR RECORDS.