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

Recertifications may be processed using this form for all NYSAFEs who are in the final five months of their current certification period, or no more than four months past the expiration of their last valid certification period.

Applications will only be accepted if the information marked with an asterisk is complete and all required 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. We 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: _____

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: _____

Continuing Education Attestation

I attest, under penalty of perjury, that I have successfully completed at least 15 hours of education related to the field of forensic science, in accordance acceptable topics, within the past three years. Acceptable topics include:

- Dynamics of sexual assault
- Trauma informed care
- Sexual assault response teams
- Examiner roles and responsibilities
- Crisis intervention
- Cultural competency
- Injury detection and documentation
- Physical assessment and evaluation
- Collection and handling forensic evidence
- Documentation procedures
- Post-exposure care for sexually transmitted diseases
- Post-exposure care for blood-borne diseases
- Post-exposure care for pregnancy
- Use of specialized equipment
- Judicial processes and courtroom testimony
- Patient and parental rights
- Confidentiality and consent
- Laws, regulations, and standards
- Drug facilitated sexual assault
- Ethical issues
- Follow-up and referral

I understand that it is my responsibility to provide all supporting documentation necessary for the verification of my education, 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: _____

Medical Director Attestation

I attest, under penalty of perjury, that the applicant has maintained competency in providing sexual assault medical forensic exams. I understand that if the applicant has had more than a one-year lapse in service during the three-year certification period, I must explain how competency was maintained or updated, i.e., by means of repeating training or by other means, in an attached letter.

Physician Name and Title: _____

Physician 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.