

West Virginia Sexual Assault Nurse Examiner (SANE) Program Pediatric/Adolescent Clinical Training Log

Name	
Address	
City/State/Zip Code	
Telephone Number	
Email Address	
Date Pediatric/Adolescent SANE Didactic Training Completed	
Name of Primary Preceptor	
Preceptor Contact Information	

This West Virginia SANE Program Clinical Log is the documentation tool and clinical requirements guide for the West Virginia Pediatric/Adolescent SANE Program. The goal of the Pediatric/Adolescent Clinical SANE Training is for the clinician to become proficient and demonstrate competency in caring for the pediatric/adolescent sexual assault/abuse patient.

Competency represents minimal, novice skill development for the comprehensive care of pediatric and adolescent patients reporting sexual assault. Upon completion of the SANE didactic course, the licensed registered nurse in collaborating institutions must demonstrate an understanding of the didactic materials and demonstrate psychomotor skills that implement principles for comprehensive and efficient care of the pediatric and adolescent patient reporting sexual assault.

To independently perform medical forensic examinations on pediatric/adolescent (defined as prepubertal and adolescent patients up to 18 years of age) sexual assault patients, the registered nurse must complete and maintain certificates for both:

- Pediatric/Adolescent 40-hour didactic SANE training (Approved by the SAFE Commission)
- Pediatric/Adolescent clinical SANE training consistent with West Virginia SANE Program clinical training guidelines.

The outlined requirements are the **minimum** clinical training standards for the pediatric/adolescent SANE in West Virginia and are consistent with the guidelines established by the International Association of Forensic Nurses (IAFN).

Clinical training includes the following mandatory requirements	Date Completed
1. Pediatric/Adolescent Well Exams	
2. Specialized Equipment Proficiency Training	
3. Three Additional Training Opportunities	
4. Medical Forensic Exams and Competency Validation Tool	
5. Initial Preceptorship and Ongoing Expert Case Review	
6. Completion of the West Virginia Pediatric SANE Skills Day*	

*If the facility where the SANE candidate works has an established SANE skills training that can be used as a substitute for the West Virginia Pediatric Clinical Skills training, they may attend their facility training once the agenda and outline descriptions have been discussed and approved by the WV SANE Project Coordinator.

1. Pediatric/Adolescent Well Exams

Primary Goal: To provide training and practice obtaining a history and physical, head-to-toe exam, and demonstrate the unique approaches to assessing pediatric patients of varying developmental stages. The goal of this training is to allow the learner the ability to interact with varying ages of pediatric patients, identifying the differing approaches to gathering a history and physical and performing an assessment on a variety of developmental age groups. If permitted, perform the well exam with your preceptor directly observing you gathering the history and physical (H&P) and head-to-toe examination process. Document any findings, methods of assessment used, or specific techniques and approaches used to facilitate the examination of the child. **If unable to perform the well exam, directly observe your preceptor performing these, noting the methods of assessment, techniques, and approaches used to facilitate the examination.** Document any findings during the examination.

This section must be completed with a medical provider experienced in providing routine care to pediatric patients, such as a PA-C, APRN, Pediatrician, SANE-P, PA-SANE, or PA-SAFE.

Complete a minimum of 15 assessments, including a variety of genders and at least 3 exams per each developmental stage.

Examples of clinical sites include well-baby clinics, family practice offices, pediatrician's offices, emergency departments, or in-patient pediatric units.

Developmental Stage	Age
Newborn/Infant	0 to 12 months
Toddler	1 year to 3 years
Preschool	3 years to 6 years
School Age	6 years to 12 years
Adolescent	12 years to 18 years

Provide a summary for each of the pediatric/adolescent physical assessments below on the chart provided. A preceptor signature must be provided for each assessment. (O: Observed Preceptor Perform, D: Demonstrated)

Date	Age	Developmental Stage	H&P	Head-To-Toe	Findings/Methods of Assessment/Techniques Used (held by parent, choices given during exam, etc.)	Preceptor Signature
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title

Date	Age	Developmental Stage	H&P	Head-To-Toe	Findings/Methods of Assessment/Techniques Used (held by parent, choices given during exam, etc.)	Preceptor Signature
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title

Date	Age	Developmental Stage	H&P	Head-To-Toe	Findings/Methods of Assessment/Techniques Used (held by parent, choices given during exam, etc.)	Preceptor Signature
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title

Additional Well Exams

Date	Age	Developmental Stage	H&P	Head-To-Toe	Findings/Methods of Assessment/Techniques Used (held by parent, choices given during exam, etc.)	Preceptor Signature
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title
		<input type="checkbox"/> Newborn/Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool <input type="checkbox"/> School Age <input type="checkbox"/> Adolescent	<input type="checkbox"/> O <input type="checkbox"/> D	<input type="checkbox"/> O <input type="checkbox"/> D		<hr/> Signature <hr/> Printed Name and Title

2. Specialized Equipment Proficiency Training

Primary Goal: To gain knowledge in the use of a colposcope, digital camera, alternative light source, Toluidine blue dye, foley catheter or Fox swabs, or other specialized equipment utilized during ano-genital assessments.

Training is required for each piece of equipment that a facility utilizes. This skills training practice should not be conducted on a patient reporting sexual assault.

Date: _____ Equipment Type: Alternative Light Source
Preceptor Name, Title, and Signature: _____
Preceptor Contact Phone or Email: _____
Proficient: Y N Suggested Remediation: Y N
Comments: _____

Date: _____ Equipment Type: Digital Camera or Colposcope
Preceptor Name, Title, and Signature: _____
Preceptor Contact Phone or Email: _____
Proficient: Y N Suggested Remediation: Y N
Comments: _____

Date: _____ Equipment Type: Foley Cath
Preceptor Name, Title, and Signature: _____
Preceptor Contact Phone or Email: _____
Proficient: Y N Suggested Remediation: Y N
Comments: _____

Date: _____ Equipment Type: Fox Swab
Preceptor Name, Title, and Signature: _____
Preceptor Contact Phone or Email: _____
Proficient: Y N Suggested Remediation: Y N
Comments: _____

Date: _____ Equipment Type: Toluidine Blue Dye
Preceptor Name, Title, and Signature: _____
Preceptor Contact Phone or Email: _____
Proficient: Y N Suggested Remediation: Y N
Comments: _____

3. Minimum of Three Additional Training Opportunities

The clinician must complete **at least 3** of the following activities. Meeting with the local Child Advocacy Center and attending your local Multidisciplinary Investigative Team (MDIT) are mandatory experiences.

a. **Meeting with your local child advocacy center (CAC)**

Primary Goal: To establish a collaborative relationship with local CAC and learn about services provided. **This experience is required.**

Date: _____ Time Spent: _____

Location/Agency: _____

Name, Title, and Signature of the Individual who witnessed your attendance: _____

Contact Phone or Email: _____

b. **Meeting with your local Multidisciplinary Investigative Team (MDIT)**

Primary Goal: To establish a collaborative relationship with the local MDIT and learn about the role of the MDIT within the community. **This experience is required.**

Date: _____ Time Spent: _____

Location/Agency: _____

Name, Title, and Signature of the Individual who witnessed your attendance: _____

Contact Phone or Email: _____

c. **Meeting with the WV SANE Project Coordinator or hospital-based SANE Project Coordinator**

Primary Goal: To establish a relationship and obtain input on collecting forensic samples

Date: _____ Time Spent: _____

Location/Agency: _____

Name, Title, and Signature of the Individual who witnessed your attendance: _____

Contact Phone or Email: _____

d. **Child Sexual Abuse Assessment SANE/SAFE Forensic Learning Series Workbook**

The clinician should purchase and work through the Child Sexual Abuse Assessment SANE/SAFE Forensic Learning Series Workbook. Upon completing, write a 2-3 paragraph summary about what they learned, what they found most helpful, and any outstanding questions or concerns that were identified when completing the material. Please attach the write-up of the workbook to this packet with your submission.

e. **Law Enforcement Agency**

Primary Goal: To establish a collaborative relationship with the local law enforcement agency/sex crimes unit.

Date: _____ Time Spent: _____

Location/Agency: _____

Name, Title, and Signature of the Individual who witnessed your attendance:

Contact Phone or Email:

f. **Observation at Child Abuse Criminal Trial Proceedings**

Primary Goal: To observe and become familiar with child abuse criminal proceedings, particularly direct and cross-examination of an expert witness. Examples include attending a pertinent conference or visiting a coroner's office.

Date: _____ Time Spent: _____

Location: _____

Name and Title of Witness Observed:

Name, Title, and Signature of the Individual who witnessed your attendance:

Contact Phone or Email:

g. **Additional Relevant Experiences**

Primary Goal: To gain clinical knowledge through additional relevant experiences. Examples include attending a pertinent conference or visiting a coroner's office.

Date: _____ Time Spent: _____

Location/Agency: _____

Name, Title, and Signature of the Individual who witnessed your attendance:

Contact Phone or Email:

h. **Additional Relevant Experiences**

Primary Goal: To gain clinical knowledge through additional relevant experiences. Examples include attending a pertinent conference or visiting a coroner's office.

Date: _____ Time Spent: _____

Location/Agency: _____

Name, Title, and Signature of the Individual who witnessed your attendance:

Contact Phone or Email:

4. Medical Forensic Examinations

Primary Goal: To gain competency in conducting pediatric/adolescent medical forensic examination, including the use of informed consent, medical forensic history taking, head-to-toe assessments, detailed ano-genital exams, evidence collection using the West Virginia Sexual Assault Evidence Collection Kit (WV SAECK) if warranted, providing discharge instructions including STI/HIV prophylaxis and pregnancy prevention, planning for follow-up care, safety planning and the use of specialized examination techniques including forensic photography. To differentiate between normal or normal variants versus abnormal findings in the pediatric/adolescent sexual assault/abuse patient.

A **minimum** of 3 examinations is required. Exams may be a mix of acute and nonacute cases. These examinations may be mock scenarios. You may document additional exams if you have the opportunity to complete more than 3 exams before completing your clinical log.

All medical forensic examinations must be completed with a preceptor. Your preceptor must be a Child Abuse Pediatrician, PA SAFE, SANE-P, or PA SANE. This preceptorship may be completed through the use of virtual platforms and does not necessarily need to be in-person.

Provide a summary for each exam, including mock exams, on the forms provided below. Do not include names or confidential patient information. You may include a copy of your documentation as your summary with redacted patient identifying information.

The Clinical Competency Validation Tool must be filled out by the preceptor after they feel the clinician is confident and competent in their ability to perform a medical forensic exam independently.

Exam 1	Date:	Time:	Exam Location:	
Preceptor:		Preceptor Contact Information:		
Age of patient:	Gender of Patient:	Patient Tanner Stage: Breast _____		Time elapsed since contact:
Age of assailant:	Assailant relationship to patient:	Genital _____ Pubic Hair _____		
Disclosure: <input type="checkbox"/> Yes (to whom): _____ <input type="checkbox"/> No	Hymen: <input type="checkbox"/> Annular <input type="checkbox"/> Crescentic <input type="checkbox"/> Estrogenized <input type="checkbox"/> Un-estrogenized <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A Additional description: _____		Penis/Testes: <input type="checkbox"/> Circumcised <input type="checkbox"/> Uncircumcised <input type="checkbox"/> Testes descended <input type="checkbox"/> Testes undescended Additional description: _____	
Position(s) Utilized: <input type="checkbox"/> Supine knee-chest <input type="checkbox"/> Prone knee-chest <input type="checkbox"/> Supine frog leg <input type="checkbox"/> Lithotomy (adolescent only)				
Specialized Equipment and Visualization Technique:				
Patient History: _____ _____ _____ _____				
Person(s) Providing History:			Who was present during the history:	
Description and Interpretation of Findings: _____ _____ _____				
Treatment Provided: _____				
Check the Appropriate Response: Concern for abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No Evidence collected: <input type="checkbox"/> Yes <input type="checkbox"/> No Law Enforcement notified: <input type="checkbox"/> Yes <input type="checkbox"/> No CPS notified: <input type="checkbox"/> Yes <input type="checkbox"/> No STI Testing: <input type="checkbox"/> Yes <input type="checkbox"/> No Description of testing: _____ Prophylaxis/Emergency contraceptive: <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s) provided: _____ Safety plan for discharge: _____ Follow-up recommended: _____				
Expert Case Review By: _____ Date: _____				

Exam 2	Date:	Time:	Exam Location:	
Preceptor:		Preceptor Contact Information:		
Age of patient:	Gender of Patient:	Patient Tanner Stage: Breast _____		Time elapsed since contact:
Age of assailant:	Assailant relationship to patient:	Genital _____ Pubic Hair _____		
Disclosure: <input type="checkbox"/> Yes (to whom): _____ <input type="checkbox"/> No	Hymen: <input type="checkbox"/> Annular <input type="checkbox"/> Crescentic <input type="checkbox"/> Estrogenized <input type="checkbox"/> Un-estrogenized <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A Additional description: _____		Penis/Testes: <input checked="" type="checkbox"/> Circumcised <input type="checkbox"/> Uncircumcised <input type="checkbox"/> Testes descended <input type="checkbox"/> Testes undescended Additional description: _____	
Position(s) Utilized: <input type="checkbox"/> Supine knee-chest <input type="checkbox"/> Prone knee-chest <input type="checkbox"/> Supine frog leg <input type="checkbox"/> Lithotomy (adolescent only)				
Specialized Equipment and Visualization Technique:				
Patient History: _____ _____ _____				
Person(s) Providing History:			Who was present during the history:	
Description and Interpretation of Findings: _____ _____ _____				
Treatment Provided: _____				
Check the Appropriate Response: Concern for abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No Evidence collected: <input type="checkbox"/> Yes <input type="checkbox"/> No Law Enforcement notified: <input type="checkbox"/> Yes <input type="checkbox"/> No CPS notified: <input type="checkbox"/> Yes <input type="checkbox"/> No STI Testing: <input type="checkbox"/> Yes <input type="checkbox"/> No Description of testing: _____ Prophylaxis/Emergency contraceptive: <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s) provided: _____ Safety plan for discharge: _____ Follow-up recommended: _____				
Expert Case Review By: _____ Date: _____				

Exam 3	Date:	Time:	Exam Location:	
Preceptor:		Preceptor Contact Information:		
Age of patient:	Gender of Patient:	Patient Tanner Stage: Breast _____		Time elapsed since contact:
Age of assailant:	Assailant relationship to patient:	Genital _____ Pubic Hair _____		
Disclosure: <input type="checkbox"/> Yes (to whom): _____ <input type="checkbox"/> No	Hymen: <input type="checkbox"/> Annular <input type="checkbox"/> Crescentic <input type="checkbox"/> Estrogenized <input type="checkbox"/> Un-estrogenized <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A Additional description: _____		Penis/Testes: <input checked="" type="checkbox"/> Circumcised <input type="checkbox"/> Uncircumcised <input type="checkbox"/> Testes descended <input type="checkbox"/> Testes undescended Additional description: _____	
Position(s) Utilized: <input type="checkbox"/> Supine knee-chest <input type="checkbox"/> Prone knee-chest <input type="checkbox"/> Supine frog leg <input type="checkbox"/> Lithotomy (adolescent only)				
Specialized Equipment and Visualization Technique:				
Patient History: _____ _____ _____				
Person(s) Providing History:			Who was present during the history:	
Description and Interpretation of Findings: _____ _____ _____				
Treatment Provided: _____				
Check the Appropriate Response: Concern for abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No Evidence collected: <input type="checkbox"/> Yes <input type="checkbox"/> No Law Enforcement notified: <input type="checkbox"/> Yes <input type="checkbox"/> No CPS notified: <input type="checkbox"/> Yes <input type="checkbox"/> No STI Testing: <input type="checkbox"/> Yes <input type="checkbox"/> No Description of testing: _____ Prophylaxis/Emergency contraceptive: <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s) provided: _____ Safety plan for discharge: _____ Follow-up recommended: _____				
Expert Case Review By: _____ Date: _____				

Exam 4	Date:	Time:	Exam Location:	
Preceptor:		Preceptor Contact Information:		
Age of patient:	Gender of Patient:	Patient Tanner Stage: Breast _____	Time elapsed since contact:	
Age of assailant:	Assailant relationship to patient:	Genital _____ Pubic Hair _____		
Disclosure: <input type="checkbox"/> Yes (to whom): _____ <input type="checkbox"/> No	Hymen: <input type="checkbox"/> Annular <input type="checkbox"/> Crescentic <input type="checkbox"/> Estrogenized <input type="checkbox"/> Un-estrogenized <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A Additional description: _____	Penis/Testes: <input checked="" type="checkbox"/> Circumcised <input type="checkbox"/> Uncircumcised <input type="checkbox"/> Testes descended <input type="checkbox"/> Testes undescended Additional description: _____		
Position(s) Utilized: <input type="checkbox"/> Supine knee-chest <input type="checkbox"/> Prone knee-chest <input type="checkbox"/> Supine frog leg <input type="checkbox"/> Lithotomy (adolescent only)				
Specialized Equipment and Visualization Technique:				
Patient History: _____ _____ _____				
Person(s) Providing History:		Who was present during the history:		
Description and Interpretation of Findings: _____ _____ _____				
Treatment Provided: _____				
Check the Appropriate Response: Concern for abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No Evidence collected: <input type="checkbox"/> Yes <input type="checkbox"/> No Law Enforcement notified: <input type="checkbox"/> Yes <input type="checkbox"/> No CPS notified: <input type="checkbox"/> Yes <input type="checkbox"/> No STI Testing: <input type="checkbox"/> Yes <input type="checkbox"/> No Description of testing: _____ Prophylaxis/Emergency contraceptive: <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s) provided: _____ Safety plan for discharge: _____ Follow up recommended: _____				
Expert Case Review By: _____ Date: _____				

Exam 5	Date:	Time:	Exam Location:	
Preceptor:		Preceptor Contact Information:		
Age of patient:	Gender of Patient:	Patient Tanner Stage: Breast _____	Time elapsed since contact:	
Age of assailant:	Assailant relationship to patient:	Genital _____ Pubic Hair _____		
Disclosure: <input type="checkbox"/> Yes (to whom): _____ <input type="checkbox"/> No	Hymen: <input type="checkbox"/> Annular <input type="checkbox"/> Crescentic <input type="checkbox"/> Estrogenized <input type="checkbox"/> Un-estrogenized <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A Additional description: _____	Penis/Testes: <input checked="" type="checkbox"/> Circumcised <input type="checkbox"/> Uncircumcised <input type="checkbox"/> Testes descended <input type="checkbox"/> Testes undescended Additional description: _____		
Position(s) Utilized: <input type="checkbox"/> Supine knee-chest <input type="checkbox"/> Prone knee-chest <input type="checkbox"/> Supine frog leg <input type="checkbox"/> Lithotomy (adolescent only)				
Specialized Equipment and Visualization Technique:				
Patient History: _____ _____ _____ _____				
Person(s) Providing History:		Who was present during the history:		
Description and Interpretation of Findings: _____ _____ _____				
Treatment Provided: _____				
Check the Appropriate Response: Concern for abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No Evidence collected: <input type="checkbox"/> Yes <input type="checkbox"/> No Law Enforcement notified: <input type="checkbox"/> Yes <input type="checkbox"/> No CPS notified: <input type="checkbox"/> Yes <input type="checkbox"/> No STI Testing: <input type="checkbox"/> Yes <input type="checkbox"/> No Description of testing: _____ Prophylaxis/Emergency contraceptive: <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s) provided: _____ Safety plan for discharge: _____ Follow-up recommended: _____				
Expert Case Review By: _____ Date: _____				

Exam ____	Date:	Time:	Exam Location:	
Preceptor:		Preceptor Contact Information:		
Age of patient:	Gender of Patient:	Patient Tanner Stage: Breast ____	Time elapsed since contact:	
Age of assailant:	Assailant relationship to patient:	Genital ____ Pubic Hair ____		
Disclosure: <input type="checkbox"/> Yes (to whom): _____ <input type="checkbox"/> No	Hymen: <input type="checkbox"/> Annular <input type="checkbox"/> Crescentic <input type="checkbox"/> Estrogenized <input type="checkbox"/> Un-estrogenized <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A Additional description: _____	Penis/Testes: <input checked="" type="checkbox"/> Circumcised <input type="checkbox"/> Uncircumcised <input type="checkbox"/> Testes descended <input type="checkbox"/> Testes undescended Additional description: _____		
Position(s) Utilized: <input type="checkbox"/> Supine knee-chest <input type="checkbox"/> Prone knee-chest <input type="checkbox"/> Supine frog leg <input type="checkbox"/> Lithotomy (adolescent only)				
Specialized Equipment and Visualization Technique:				
Patient History: _____ _____ _____ _____				
Person(s) Providing History:			Who was present during the history:	
Description and Interpretation of Findings: _____ _____ _____				
Treatment Provided: _____				
Check the Appropriate Response: Concern for abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No Evidence collected: <input type="checkbox"/> Yes <input type="checkbox"/> No Law Enforcement notified: <input type="checkbox"/> Yes <input type="checkbox"/> No CPS notified: <input type="checkbox"/> Yes <input type="checkbox"/> No STI Testing: <input type="checkbox"/> Yes <input type="checkbox"/> No Description of testing: _____ Prophylaxis/Emergency contraceptive: <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s) provided: _____ Safety plan for discharge: _____ Follow-up recommended: _____				
Expert Case Review By: _____ Date: _____				

Exam ____	Date:	Time:	Exam Location:	
Preceptor:		Preceptor Contact Information:		
Age of patient:	Gender of Patient:	Patient Tanner Stage: Breast ____	Time elapsed since contact:	
Age of assailant:	Assailant relationship to patient:	Genital ____ Pubic Hair ____		
Disclosure: <input type="checkbox"/> Yes (to whom): _____ <input type="checkbox"/> No	Hymen: <input type="checkbox"/> Annular <input type="checkbox"/> Crescentic <input type="checkbox"/> Estrogenized <input type="checkbox"/> Un-estrogenized <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A Additional description: _____	Penis/Testes: <input checked="" type="checkbox"/> Circumcised <input type="checkbox"/> Uncircumcised <input type="checkbox"/> Testes descended <input type="checkbox"/> Testes undescended Additional description: _____		
Position(s) Utilized: <input type="checkbox"/> Supine knee-chest <input type="checkbox"/> Prone knee-chest <input type="checkbox"/> Supine frog leg <input type="checkbox"/> Lithotomy (adolescent only)				
Specialized Equipment and Visualization Technique:				
Patient History: _____ _____ _____ _____				
Person(s) Providing History:		Who was present during the history:		
Description and Interpretation of Findings: _____ _____ _____				
Treatment Provided: _____				
Check the Appropriate Response: Concern for abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No Evidence collected: <input type="checkbox"/> Yes <input type="checkbox"/> No Law Enforcement notified: <input type="checkbox"/> Yes <input type="checkbox"/> No CPS notified: <input type="checkbox"/> Yes <input type="checkbox"/> No STI Testing: <input type="checkbox"/> Yes <input type="checkbox"/> No Description of testing: _____ Prophylaxis/Emergency contraceptive: <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s) provided: _____ Safety plan for discharge: _____ Follow-up recommended: _____				
Expert Case Review By: _____ Date: _____				

Clinical Competency Validation Tool

Pediatric/Adolescent Medical Forensic Examinations

Competency Statement: The performance of the SANE requires proper techniques as outlined by the International Association of Forensic Nurses. The list provided below is not all-inclusive of all requirements; however, the list includes the **minimum** criteria necessary to practice as a PA SANE.

***Preceptor Instructions:** Mark how the clinician met the standard by either **O**: observation of patient interaction in the clinical setting, **D**: demonstration in a simulation lab, or **V**: verbal review.

Performance Measures/Criteria	How Met *O; D; V	Preceptor Initials
1. Explains/provides to the patient <ul style="list-style-type: none"> ○ Informed consent/assent ○ Procedures and equipment/techniques utilized ○ Rights of privacy and confidentiality 		
2. Obtains medical and forensic history using a trauma-informed approach and documents thoroughly according to agency standards. Medical and forensic history to include: <ul style="list-style-type: none"> ● Review of Systems ● Health History ● Immunization Status ● History of Event ● Living Environment ● Safety Assessment 		
3. Performs a thorough, patient-centered head-to-toe assessment, including detailed anogenital assessment using a speculum (when appropriate) and other techniques and/or equipment. Anogenital exam techniques to include: <ul style="list-style-type: none"> ● Labial separation ● Labial traction ● Supine frog-leg position ● Prone knee-chest position 		
4. Identifies, interprets and appropriately documents findings based upon Adams criteria of: <ul style="list-style-type: none"> ○ Normal exam ○ Normal variants ○ Findings consistent with other medical condition ○ No expert consensus ○ Diagnostic findings consistent with trauma/abuse 		
5. Using proper techniques, collects appropriate evidence according to local protocol, documents and maintains chain of custody of evidence		
6. Identifies and performs specimen collection for drug-facilitated or alcohol-facilitated sexual assault, sexually transmitted infection, pregnancy, and HIV testing.		

<p>7. Using proper techniques, performs forensic photography accurately, including use of:</p> <ul style="list-style-type: none"> • Proper use of digital camera • Proper use of colposcope 		
<p>8. Identifies genital anatomy, including:</p> <ul style="list-style-type: none"> • Labia majora • Labia minora • Clitoral hood • Clitoris • Vestibule • Urethral meatus • Fossa navicularis • Posterior fourchette • Hymen • Vagina • Cervix • Cervical os • Perineum • Anus • Penis • Scrotum • Testes 		
<p>9. Performs psychosocial assessment that includes:</p> <ul style="list-style-type: none"> ○ Crisis intervention ○ Suicide and safety assessment and planning ○ Referrals ○ Culturally sensitive approach 		
<p>10. Provides appropriate medication administration, discharge instructions and other referrals based on the patient's needs</p>		
<p>11. Works with members of the multi-disciplinary team, including the local child advocacy center, CPS worker, rape crisis center advocate, and law enforcement. Discusses MDT partners and their roles, including:</p> <ul style="list-style-type: none"> • Forensic interviewer • Child protection • Law enforcement • Victim advocate • Prosecutor • Medical provider 		
<p>12. Differentiates between forensic interview and medical history</p>		
<p>13. Discusses expectations of subpoena and court testimony</p>		
<p>Preceptor Name, Title, and Signature (Child Abuse Pediatrician, PA-SAFE, SANE-P, or PA SANE):</p>		
<p>Preceptor Contact Phone or Email:</p>		
<p>Date of Competency Validation:</p>		

The course clinical log must be completed and a **copy** submitted to the West Virginia SANE Coordinator with **12 months** of your Pediatric/Adolescent didactic SANE training. It is highly recommended that you contact the West Virginia SANE Coordinator six months after your didactic training if you are having difficulty completing any of your requirements. If you need more room to describe your clinical experiences, please attach additional paper. **Please type or write legibly.** Any questions regarding these requirements should be directed to the West Virginia SANE Coordinator. These are minimum standards for West Virginia. Your institution and/or the West Virginia SANE Coordinator may require additional clinical experiences to validate your competency.

You must include the following as a component of your clinical training:

- A copy of certificate of completion of the West Virginia Pediatric Clinical Skills day.*
*If local SANE program performed training, please submit certificate of completion.

If you attended a SANE training other than that provided by WVFRIS, please submit a copy of your training certificate of completion and agenda.

After review and approval of documentation, you will be mailed a certificate of completion for clinical training requirements. Having a certificate of completion for **both** didactic and clinical training allows you to practice as an PA-SANE in the State of West Virginia. If you will be practicing as an PA-SANE, you may write this title below your signature as a description of your job title.

This does not mean that you are certified as a Pediatric/Adolescent SANE. Certification is granted through the Forensic Nursing Certification Board after passing an exam or submitting a portfolio. The clinical training certificate provides proof of Pediatric/Adolescent clinical SANE training, which will allow you to sit for the certification exam. Please visit the International Association of Forensic Nurses website at www.forensicnurses.org for more information. Obtaining the clinical training certificate will also assist in qualifying the Pediatric/Adolescent SANE as an expert witness in criminal/civil court proceedings.

Upon completion of all clinical requirements, email a copy of your clinical training log and other documentation to:

Brittany DeCrease, BSN, RN
West Virginia SANE Project Coordinator
Email: wvsanecoordinator@fris.org
Cell: 304-941-9644

West Virginia SANE Practice Application

Type of application (Check all that apply)

<input type="checkbox"/> Adult SANE (AA-SANE)	<input type="checkbox"/> Pediatric SANE (PA-SANE)
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Applicant's Information

Applicant Name (as it appears on RN License, print legibly)		Phone Number
Home Mailing Address		Alternate Phone Number (Optional)
City	State	Zip Code
WV RN License Number	Email Address	

Location of SANE Practice (must be WV facility)

Name of Primary Facility	Facility Phone Number	
Facility Mailing Address	County	City

SANE Coordinator Information (or direct manager if no SANE Coordinator)

SANE Coordinator's Name	SANE Coordinator's Phone Number
SANE Coordinator's Email	

Applicant Verification

I, _____ (*print name*), verify that all minimum requirements for SANE practice in West Virginia have been completed as required by WVFRIS. I verify that all information provided in this application and other supporting documentation is true and correct to the best of my knowledge. I authorize any organization or individual who has information relating to my application to release it to WVFRIS as needed to process this application. I understand that WVFRIS or any agent or representative of WVFRIS, has the right to review, investigate, and verify the information provided. I understand it is my responsibility to maintain all documents (including copies of this application). It is not the responsibility of WVFRIS to maintain my documentation on my behalf. I must maintain my documentation as I may be subject to audit at any time. I understand and agree that if false, misleading, or intentionally incomplete information is provided my application may be denied.

Applicant's Signature: _____ **Date:** _____