

SEXUAL ASSAULT EXAMINATION CERTIFICATE

Facility Name: _____
 Facility Address: _____
 Date and Time of Examination: _____
 County and State Where Assault Occurred: _____
 Date and Time of Assault: _____

PATIENT INFORMATION

Female _____ Male _____
 Date of Birth: _____ Age: _____
 Social Security Number _____
 Patient Number _____
 Does the patient have any health insurance coverage (public or private)?
 YES _____ NO _____

PHYSICIAN/S.A.N.E. CERTIFICATION

I hereby certify that a forensic sexual assault examination was performed by me upon the above-named patient on the _____ day of _____, 20_____.

 Physician (Print Name)

 S.A.N.E. (Print Name)

OR

 License Number

 License Number

 Signature

 Signature

CERTIFICATION OF NOTIFICATION TO LAW ENFORCEMENT

I hereby certify that _____ with _____
(Name and Title) (Law Enforcement Agency and telephone number)

was notified of the above-reported sexual assault on the _____ day of _____, 20_____.

_____ **Place check mark here if reported victim wishes to withhold reporting the incident to law enforcement**

 (Facility Employee's Signature)

 (Facility Employee's Printed Name and Title)

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I, _____, hereby authorize the facility and physician/S.A.N.E. named above
(Name of Patient or Minor Patient's Parent/Guardian)
 to release the Sexual Assault Examination Certificate and itemized billing statement(s) for the forensic sexual assault examination to the Sexual Assault Examination Program for the purpose of enabling the above-named facility, as well as the examining physician or S.A.N.E., to present a claim for payment of the forensic examination expenses.

 (Signature of Patient or Minor Patient's Parent/Guardian)

 (Date)

NOTICE TO PATIENT OR PARENT/GUARDIAN:

- * You should not receive any billing statements for the forensic services rendered on this date. However, if you do, please contact the Crime Victims Compensation Board at (502) 573-2290 or toll free at 1-800-469-2120.
- * Please also note that withholding an incident from law enforcement may jeopardize any claim with the Crime Victims Compensation Board for other expenses related to the incident but are not a part of the sexual assault examination.

Send this completed form with itemized billing statement(s) to:

Sexual Assault Examination Program
 c/o Crime Victims Compensation Board
 130 Brighton Park Blvd.
 Frankfort, KY 40601-3417

Billing Questions?
 Contact CVCB at
 (502) 573-2290 or
www.cvcb.ky.gov/saep