Sexual Assault Nurse Examiner (SANE) Program
Qualified Medical Provider (QMP) Verification Request Form

REQUESTER INFORMATION:

Requester Name: _____

Title/Position: _____

Organization/Employer: _____

Department (if applicable): _____

Email (preferred): _____

TYPE OF REQUESTER (select one):

☐ SANE Coordinator

☐ Current Employer

☐ Prospective Employer

☐ Agency/Organization

INDIVIDUAL WHOSE STATUS IS BEING VERIFIED:

Full Legal Name: _____

Professional License Number: _____

**Verification will be conducted using full legal name and professional license number.*

REQUESTER ATTESTATION:

I attest that this request is solely for credential verification purposes. I understand that the individual whose information is being requested, will be notified of this request and must provide authorization for disclosure before any information is released. I acknowledge that no training certificates or supporting documentation will be released. Only QMP status, classification, and date of approval (if applicable) may be shared following authorization from the individual.

Requester Signature: _____ Date: _____

SUBMISSION INSTRUCTIONS:

Submit the completed QMP Verification Request Form to: SANE@ilag.gov.

RESPONSE TIMELINE:

The OAG SANE Program will review and process requests in the order received and will respond as quickly as possible, but no later than 10 business days from receipt of completed request. Processing may be delayed if additional time is needed to obtain authorization for release of information. The requester will be notified if the authorization was declined.

For Office Use Only:

Date Rec'd _____ | **Staff** _____ **Auth. Rec'd** _____ | **Staff** _____

Notif. Sent _____ | **Staff** _____ **Resp. Sent** _____ | **Staff** _____