Washington State Department of Health

Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY	
VALIDATION:	DATE RECEIVED
CERTIFICATE#	ISSUANCE DATE

CERTIFICATE #

APPLICATION FOR SEX OFFENDER TREATMENT PROVIDER

Applying for: ❒ Sex Offender Treatment Provider Certificate ❒ Sex Offender Treatment Provider Affiliate ❒ Sex Offender Treatment Provider Exam

Please Type or Print Clearly - Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

1. DEMOGRAPHIC INFORMATION

APPLICANT'S NAME	LAST	FIRST	MIDDLE INITIAL

RESIDENTIAL ADDRESS			
CITY	STATE	ZIP	COUNTY

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.)	SOCIAL SECURITY NUMBER

GENDER	BIRTHDATE (MO/DAY/YR)	PLACE OF BIRTH
❒ Female ❒ Male		

Have you ever been known under any other name? ❒ Yes ❒ No

If yes, list full name(s)

2. WASHINGTON STATE LICENSURE/CERTIFICATION/REGISTRATION INFORMATION

PROFESSION	ISSUE DATE	LICENSE/CERT/REG. NO.

3. PREVIOUS LICENSURE OR CERTIFICATION

List all states where certificate(s) or licenses are or were held. (Previous credential to include license, certification or registration.) Specifically list certificate(s) or licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if certificate(s) or license is current.

STATE/JURISDICTION	PROFESSION	CERTIFICATE OR LICENSE		PERMANENT OR TEMPORARY	LICENSE RECEIVED BY		CURRENTLY IN FORCE
		YR ISSUED	NUMBER		EXAMINATION	OTHER	

4. EDUCATION

Highest degree earned _____ Year _____

In the spaces below, provide a chronological listing of your educational preparation and post-graduate training. (Attach additional 8 1/2 x 11 sheet if necessary.)

FULL NAME, CITY AND STATE SCHOOLS ATTENDED	ATTENDANCE		DATE GRADUATED	DEGREE EARNED	MAJOR AREA OF STUDY	IF NO DEGREE # OF SEMESTER/QTR HRS EARNED
	ENTRANCE DATE	ENDING DATE				

5. PERSONAL DATA

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	❒	❒

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	❒	❒

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	❒	❒
4. Are you currently engaged in the illegal use of controlled substances?	❒	❒

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you must answer "yes" to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	❒	❒
b. a charge of a sex offense?	❒	❒
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	❒	❒
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	❒	❒
b. committed any act involving moral turpitude, dishonesty or corruption?	❒	❒
c. violated any state or federal law or rule regulating the practice of a health care professional?	❒	❒
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	❒	❒
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	❒	❒
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	❒	❒

6. PROFESSIONAL EXPERIENCE

In chronological order, list all professional experience. (Exclude activities listed under other sections.) (Attach additional 8 1/2 x 11 sheet if necessary.)

INDICATE NATURE OF EXPERIENCE OR PRACTICE AND LOCATION	INCLUSIVE DATES OF EXPERIENCE	
	BEGINNING DATE	ENDING DATE

WAC 246-930-040 Professional Experience Requirement for Full Certification Applicants.

1. In order to quality for examination, you must have completed at least two thousand hours of direct treatment and evaluation experience, as defined in WAC 246-930-010. At least two hundred and fifty of these hours must be evaluation experience and at least two hundred and fifty of these hours must be treatment experience.

2. All of the prerequisite experience must have been within the seven year period preceding application for certification as a provider.

Do you have 250 face-to-face hours of evaluation? ❒ Yes ❒ No
Do you have 250 face-to-face hours of treatment? ❒ Yes ❒ No
Do you have a total of 2000 hours of experience? ❒ Yes ❒ No

Describe how the hours were acquired and calculate: i.e., Please calculate your face-to-face treatment and evaluation hours for which you had primary responsibility separately to show how you established your 2000 hours (example: 6 patients per week 1 hour each totaling 6 hours per week times how many years practicing). (Attach additional 8 1/2 x 11 sheet if necessary.)

_____

_____

_____

_____

_____

List the documentation you have to substantiate your hours; e.g., (billing, affidavit of supervision, agency records): _____

_____

_____

_____

7. AFFILIATE APPLICANTS

Please provide the name, address and telephone number of your supervisor who will provide supervision when working with SSOSA and SSODA clients:

Provide a copy of the contract entered into by yourself and supervisor (WAC 246-930-075(4)).

Supervisor's Name _____

Work Telephone _____ Home Telephone _____

Supervisor's Address _____

City _____ State _____ Zip _____

8. AIDS EDUCATION AND TRAINING ATTESTATION

I certify I have completed the minimum of 4 hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my certification may be denied, or if issued, suspended or revoked.

Signature of Applicant _____ Date _____

9. APPLICANT'S ATTESTATION

I, _____, certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby agree that such an act shall constitute cause for the denial, suspension or revocation of my certification to practice in the State of Washington.

Signature of Applicant _____ Date _____

Official Use Only

Washington State Records Center

I certify that I submit to the jurisdiction of the Washington state courts for the purpose of any litigation involving my practice as a sex offender treatment provider, and that service of process may be made in such cases pursuant to RCW 4.28.180; and

That I do not intend to practice the health profession for which I am credentialed by another state within the state of Washington without first obtaining an appropriate credential to do so from the state of Washington, except as may be authorized by Washington State Law.

_____

Signature

_____

Name (**typed or printed**)

Dated this _____ day of _____, 20__

REQUEST FOR PROFESSIONAL TRAINING AND REFERENCES

Applicant's Name _____

PROFESSIONAL TRAINING (Obtained within the last three years)

List 50 hours of training (courses, seminars, formal conferences, etc.) directly related to the treatment and evaluation of sex offenders or victims of abuse, copies of program or course certificates is acceptable. Please review **WAC 246-930-070** for the training requirement.

SEMINAR NAME	DATE	LOCATION	SPONSOR	HOURS

SOURCE OF VERIFICATION

List a professional reference(s) that can verify your experience requirement. Please review **WAC 246-930-040** for the **Full** certification experience requirement and **WAC 246-930-060** for the **Affiliate** certification experience requirement.

NAME	ADDRESS	TELEPHONE

SAMPLE OF A SUPERVISORY CONTRACT BETWEEN EMPLOYER-EMPLOYEE

This contract serves as a written understanding between _____ (hereinafter referred to as "the supervisor") and _____ (hereinafter referred to as "the supervisee") regarding the provision of supervisory services by supervisor for supervisee. Supervisor is an owner and Clinical Director of _____ _____. Supervisee is employed by supervisor as a therapist. At all times pertinent hereto, supervisor shall be a Washington State Certified Sex Offender Treatment Provider and supervisee a Washington State Certified Affiliate Sex Offender Treatment Provider. This supervision agreement only applies to professional work done by supervisee involving SSODA or SSOSA eligible perpetrators of sexual misconduct under the general umbrella of supervisor's practice. The term of this agreement will be for twelve months, however, the contract can be terminated with sixty days notice by either party. At the end of twelve months, this agreement may be extended, if desired by both parties.

Cases which supervisee will see shall be referred from the practice of supervisor. Cases will be selected to meet training needs and will be appropriate to the supervisee's level of experience and competence. All professional work of this nature performed by the supervisee will remain a part of the supervisor's practice with income derived being retained by the supervisor. During the course of this agreement, the supervisee will only work with perpetrators of sexual abuse under the supervision of the supervisor. The supervisee will not engage in such work independently or through other private or public agencies. It is understood that working with perpetrators of sexual misconduct is a highly specialized area of practice and should not be pursued independently until a professional has achieved a significant level of competence in this work and achieved certified status.

The level of supervision provided shall insure the affiliate's preparedness to conduct his or her professional work and adequately oversee the affiliate's work. The level of supervision shall also oversee the affiliate's work and be consistent with WAC 246-930-075. There shall be a minimum of one hour of supervision time for every ten hours of supervised professional work. Supervision meetings shall regularly occur at least every other week. Supervision shall include: an ongoing review of clinical services provided by the supervisee; specific and ongoing review of each case or unit of the supervisee; discussion/instruction in theoretical concepts surrounding the work of the supervisee; linkage of that theoretical frame of reference to interventions within each case; psychological assessment and interpretation; discussion of referral relationships; discussion of practice management issues; review of relevant Washington state statutes and related WAC's relevant to this specific area of practice; discussion of principles and standards of practice; review of relevant reading material; review and evaluation of the supervisory relationship. Case review may include review of case notes, assessment reports and in vivo observation. Records will be kept, by both parties, regarding the number of supervisory hours and patient contact. It is anticipated that the supervisee will also do independent reading in the area of sexual deviancy as well as attend available formal training in this realm.

Supervisee shall be covered upon supervisor's professional malpractice policy at supervisor's expense. Supervisor shall have no liability for any acts performed by supervisee which are outside the scope of his/her permissible conduct as an affiliate sex offender treatment provider as defined by WAC 246-930.

It is understood that the supervisor is ethically and legally responsible for the work of the supervisee. It is within the authority of the supervisor to alter service plans or otherwise direct the course of the sex offender treatment or evaluation work.

All written work conducted by the affiliate under SSOSA or SSODA shall be cosigned by the supervisor, indicating the supervisory relationship. The work will be represented as conducted by the affiliate and with oversight provided by the supervisor. Any document that is released to a third party other than the client will be cosigned by the supervisor.

The status of the affiliate's relationship to the supervisor is to be accurately communicated to the public, other professionals and to all clients.

In the event that the supervisee does not abide by the provisions of WAC 246-930 as an affiliate sex offender treatment provider, or the supervisor does not provide the supervision required for an affiliate sex offender treatment provider as defined by WAC 246-930 on cases assigned by supervisor, either party may immediately terminate this contract.

The undersigned supervisor and supervisee have read the above information and disclosure statement, both have had the opportunity to discuss the contents with each other, and understand and agree to the meaning of this information.

SUPERVISEE PRINT NAME	**SUPERVISOR** PRINT NAME
SUPERVISEE SIGNATURE	**SUPERVISOR** SIGNATURE
DATE	**DATE**

SAMPLE OF A SUPERVISORY CONTRACT FOR PRIVATE PRACTICES

This letter will serve as a written understanding between Supervisor and Supervisee regarding the provision of services by the Supervisor for the Supervisee. Supervisee is a certified affiliate sex offender treatment provider, this supervision agreement only applies to professional work done by the supervisee involving SSODA or SSOSA clients. The term of this agreement will be for twelve months, however, the contract can be terminated with sixty days notice by either party. At the end of twelve months, this agreement may be extended, if desired by both parties.

NATURE OF SUPERVISORY RELATIONSHIP

Considering that Supervisee has already met the Department of Health's standard for treatment experience, the primary emphasis of supervision will be on the evaluation component, although supervision will encompass all aspects of Supervisee's SSODA and SSOSA work. Supervisor and Supervisee will maintain separate practices. Supervisee shall seek referrals independently, although SSODA and SSOSA cases will be reviewed by Supervisor prior to final selection. Supervision will occur on a regular basis, not less than one hour for every ten hours of SSODA/SSOSA work.

Supervision will include: an ongoing review of clinical services provided by the supervisee; specific and ongoing review of each case or work unit of the supervisee; discussion/instruction in theoretical concepts surrounding the work of the supervisee; linkage of that theoretical frame of reference to interventions within each case; assessment and interpretation; discussion of referral relationships; discussion of practice management issues; review of relevant Washington state statutes relevant to the specific area of practice; discussion of ethical principles and standards of practice; review of relevant reading material; review and evaluation of the supervisory relationship.

The supervisee will maintain thorough case notes regarding all sessions with clients and all telephone contacts with clients or collaterals. Case review may include review of case notes, assessment reports and vivo observation. The supervisor will provide the supervisee with oral feedback during regularly scheduled supervision. In addition, the supervisor will compose a written evaluation of the supervisee's performance on an annual basis. It is anticipated that the supervisee will keep his/her supervisor fully apprised of any unusual or problematic dynamics that may arise in and all cases.

Records will be kept, by both parties, regarding the number of supervisory hours and patient contact. It is anticipated that the supervisee will also do independent reading in the area of sexual deviancy as well as attend available formal training in this realm (although his/her current level of training meets the Department of Health's standards).

It is understood that the supervisor is ethically and legally responsible for the work of a supervisee. It is within the authority of the supervisor to alter Seville plans or otherwise direct the course of the SSODA and SSOSA work.

All written work produced by the affiliate under SSOSA and SSODA shall be cosigned by the supervisor, indicating the supervisory relationship. The work will be represented as conducted by the affiliate, with oversight provided by the supervisor.

The status of the affiliate's relationship to the supervisor is to be accurately communicated to the public, other professionals and to all clients served.

FINANCIAL UNDERSTANDINGS

Again, it is understood that Supervisor and Supervisee will maintain separate practices. Supervisee will provide Supervisor with an hourly fee of $_____ for any and all supervision rendered, including review of documents.

OTHER AGREEMENTS

This agreement is made with the understanding that at all times, pertinent hereto, Supervisee holds a current certificate as an affiliate sex offender treatment provider in the State of Washington and maintains professional liability insurance in the minimum amount of one million dollars.

In have read the above information and disclosure statement, have had the opportunity to discuss the contents with Supervisee and both understand and agree to the meaning of this information.

SUPERVISEE PRINT NAME	**SUPERVISOR** PRINT NAME
SUPERVISEE SIGNATURE	**SUPERVISOR** SIGNATURE
DATE	**DATE**

Washington State Department of Health
Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

OUT OF STATE VERIFICATION OF CERTIFICATION/LICENSURE AS SEX OFFENDER TREATMENT PROVIDER

To Applicant:

Please complete this section. Forward this form (copy as many as needed) to the jurisdiction of certification/licensure. Have them complete and return directly to the address above.

I, _____ am certified/licensed in the state of _____ , my certificate/license number is _____ . I have applied for a Washington State Sex Offender Treatment Provider Certificate. I authorize the release to the Washington State Sex Offender Treatment Program the information requested below.

Signature _____ Date _____

To The State Board:

Please provide **a copy of the current statute** under which the above named applicant is certified/licensed. Please return this completed form with this information to the address above. Thank you.

I hereby certify that _____ was granted professional certificate/license number _____ to practice as a sex offender treatment provider in the state of _____ on the _____ day of _____ 19 _____ on the basis of:

❒ Successfully passing the required state constructed examination

Written ❒Yes ❒No **Practical** ❒Yes ❒No

❒ Other (please explain) _____

Status of Certification/Licensure: ❒Current ❒Active ❒Inactive ❒Expiration Date _____

❒Expired ❒Dates of Expiration _____

Legal or Disciplinary Action?: ❒Yes ❒No If yes, please explain below and provide any applicable documentation.

_____

_____

_____

State Seal

Signature of Verifier _____ Date _____

Title of Verifier _____

Washington State Department of Health

SPECIAL EXAMINATION REQUIREMENTS

If you have a disability that requires special accommodation with either the written or practical portion of the examination, please complete this form and return it with your application. If you have any questions or concerns, please write to Sexual Offender Treatment Program, PO Box 47869, Olympia, WA 98504-7869.

Name		
Address		
City	**State**	**Zip**
Telephone ***(where you can be reached during normal business hours)***	**Date of Birth (mo/day/yr)**	

1. **Will you require an Oral Translator?** ☐ **Yes** ☐ **No**

   If YES, for what Language? _____

2. **Do you have a condition requiring special attention?**

   ☐ **Vision Problems** ☐ **Physical Disability** ☐ **Learning Disability** ☐ **Other (specify)** _____

3. **What special services will you need?** _____

   _____

   _____

Note: If requesting extra time, a reader, or a writer for learning disabilities, you must have your physician, optometrist, learning specialist, etc., complete the bottom section of this form.

Signature of Applicant X	**Date**

TO THE PHYSICIAN, OPTOMETRIST, LEARNING SPECIALIST ETC.

Please complete the following section regarding the candidates for the licensing/certification examination.

_____ **(applicant's Name)**

requires the following special needs for the written portion of the licensure/certification examination.

☐ **Extra Time** ☐**Reader** ☐**Writer**

Your Name ***(please type or print legibly)***	**Date**

Written Signature X	**Title**

Address	**City**

State	**Zip**	**Telephone** ***(where you can be reached during normal business hours)***