



Sex Offender Treatment Provider License Application Packet

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent or with initial application to:

Sex Offender Treatment Provider
Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Application Instructions Checklist

Important background check information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in ink. It is your responsibility to submit the required forms.

Application Fee. This fee is non-refundable. You can check the [fee page](#) for current fees.

1: Demographic Information:

Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name.

Definition of legal name: “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year you were born.

Birth place: Provide the city, state and country where you were born.

Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change.

See [WAC 246-12-310](#).

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

2: Personal Data Questions:

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

- 3: License/Certification/Registration Information**
List all health care licenses, certifications or registrations held in Washington State.
- 4: Professional Experience:**
List in chronological order all professional experience and practice from date of graduation from professional college. If you need more space, attach a piece of paper.
- 5: Professional Education:**
List in chronological order your educational preparation and post-graduate training. If you need more space, attach a piece of paper.
- 6: Other License, Certification, or Registration:**
List all states where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. If you need more space, attach a piece of paper.
- 7: Affiliate Applicants:**
Provide name, address and telephone number of your supervisor you will be using when working with clients.
- 8: AIDS Education and Training Attestation:**
AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training required by [WAC 246-12-260](#). Course content can be found in [WAC 246-12-270](#).
- 9: Applicant's Attestation:**
You must sign and date this for us to process the application. Read this very carefully.



Background
Check
Stamp
Here

Date
Stamp
Here

Revenue: 0252160000

Sex Offender Treatment Provider License Application

- Sex Offender Treatment Provider Certificate
- Sex Offender Treatment Provider Affiliate
- Sex Offender Treatment Provider Examination

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.)

- Male
- Female

Name First Middle Last

Birth date (mm/dd/yyyy)

Place of birth

City

State

Country

Address

City

State

Zip

County

Country

Phone (enter 10 digit #)

Fax (enter 10 digit #)

Cell (enter 10 digit #)

Email address

Mailing address (if different from above)

City

State

Zip

County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? Yes No

If yes, list name(s): _____

Will documents be received in another name? Yes No

If yes, list name(s): _____

For Office Use Only

Credential # _____ Issue Date _____

Validation Date _____ Received _____

2. Personal Data Questions

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 attach explanation.....

“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.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.
- 1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

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

“Currently” means within the past two years.

“Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

“Currently” means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

- a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction

Note: If you answered “yes” to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

- b. If you answered “yes” to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete?

6. Have you ever been found in any civil, administrative or criminal proceeding 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?
- b. Diverted controlled substances or legend drugs?
- c. Violated any drug law?
- d. Prescribed controlled substances for yourself?
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”, please attach an explanation 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?
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?
10. 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?

3. License/Certification/Registration

List all health care licenses, certifications or registrations held in Washington State.

Profession	Issue Date mm/dd/yyyy	License/Cert./Reg. Number

4. Education

List in chronological order your educational preparation. If you need more space, attach a piece of paper.

Schools Attended Full Name, City and State	Degree Earned	Attendance Dates	
		Start (mm/yyyy)	End (mm/yyyy)

5. Professional Experience

List in chronological order all professional experience and practice from date of graduation from professional college. Include the month/day/year. If you need more space, attach a piece of paper.

Name of Business	Total Number of Months	Dates	
		Start (mm/yyyy)	End (mm/yyyy)

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

1. In order to qualify for examination, you need at least two thousand hours of treatment and evaluation experience, as defined in [WAC 246-930-010](#) and [WAC 246-930-350](#). At least two hundred and fifty of these hours must be evaluation experience and at least two hundred fifty hours must be treatment experience.
2. All of the prerequisite experience must have been within the ten year period preceding application for certification as a provider.

Do you have 250 hours of evaluation experience? Yes No

Do you have 250 hours of treatment experience? Yes No

Do you have a total of 2000 hours of experience? Yes No

6. Other License, Certification, or Registration

List all states, including Washington, where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. If you need more space, attach a piece of paper.

State Jurisdiction	License Number	License		Method of License
		Issue Date	Expiration Date	

7. Affiliate Applicants

Provide name, address and telephone number of your supervisor which you will be using when working with clients: Provide a copy of the contract entered into by yourself and supervisor ([WAC 246-930-075\(3\)](#)).

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 four hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand if I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

9. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local, or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

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Sex Offender Treatment Provider Credentialing
 PO Box 47877
 Olympia, WA 98504-7877
 360.236.4700

Out-of-state Verification of Credential

To Applicant:

Please complete this section. Forward this form (copy as many as needed) to the jurisdiction of certification/license. 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 _____
 mm/dd/yyyy

To The State Board:

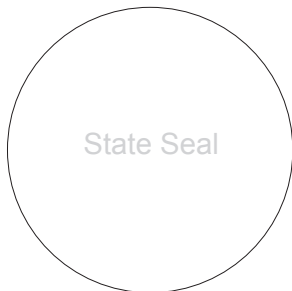
Please provide a copy of the current statute under which the above-named applicant is certified/licensed. Please return this completed form with this information to the address above. Thank you.

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

on the basis of: Successfully passing the required state constructed examination
Written Yes No **Practical** Yes No
 Other (please explain)

Status of Certification/License: 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. _____



Signature of Verifier _____
 Title of Verifier _____
 Date _____
 mm/dd/yyyy

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Sex Offender Treatment Provider Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Signed Statement

(Per [WAC 246-930-020](#))

I certify 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 service of process may be made in such cases pursuant to [RCW 4.28.180](#); and

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 _____
(Typed or Printed)

Name _____

Dated this _____ day of _____ month _____ year _____



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Sex Offender Treatment Provider Credentialing
 PO Box 47877
 Olympia, WA 98504-7877
 360.236.4700

Sex Offender Treatment Provider (SOTP) Supervision Contract

1. Affiliate Applicant			
Name	First	Middle	Last
Birth date (mm/dd/yyyy)		Underlying Credential Number	
Address			
City		State	Zip Code
2. Supervisor (Provider)			
Supervisor Name		Phone Number	
SOTP Credential Number		Underlying Credential Number	
Address			
City		State	Zip Code

WAC 246-930-075 Supervision of affiliates. Supervision of affiliates requires the provider take full ethical and legal responsibility for the quality of work of the affiliate. Supervision of affiliates shall involve regular, direct and face-to-face supervision.

This supervision contract must be submitted to the department for approval and shall include: Please attach documentation addressing these items.

- Supervised areas of professional activity.
- Amount of supervision time and the frequency of supervisory meetings. This information may be presented as a ratio of supervisory time to clinical work conducted by the affiliate.
- Supervisory fees and business arrangements.
- Nature of the supervisory relationship and the anticipated process of supervision.
- Selection and review of clinical cases.
- Methodology for record keeping, evaluation of the affiliate and feedback.
- How the affiliate will be represented to the public and the parties.

Provider:

- Avoid presenting as having qualifications in areas he or she does not have them.
- Provide sufficient training and supervision to the affiliate to assure the health and safety of the client and community.
- Have expertise and knowledge to directly supervise affiliate work.

- Assure the affiliate being supervised has sufficient and appropriate education, background and preparation for the work he or she will be doing. Cosign all written reports and correspondence prepared by the affiliate.
- Do not undertake a contract that exceeds the provider's ability to comply with the supervision standards.
- Assure the affiliate is prepared to conduct professional work. Assure adequate supervision of the affiliate. The provider shall meet face-to-face with the affiliate a minimum of one hour for every ten hours of supervised professional work. Supervision meetings occur at least every other week.
- Supervise no more than two affiliates.
- All work conducted by the affiliate is the responsibility of the provider. The provider shall have authority to direct the practice of the affiliate.
- It is the provider's responsibility to correct problems or end the supervision contract if the affiliate's work does not protect the interests of the clients and community. If the provider ends the contract, he or she must notify the department in writing within thirty days of ending the contract. A provider may only change or adjust a supervision contract after receiving written approval from the department.
- Supervision is a power relationship. The provider must not use his or her position to take advantage of the affiliate.
- The provider shall ensure the affiliate has completed at least one thousand hours of supervised evaluation and treatment experience before the affiliate is authorized to evaluate and treat Level III sex offenders. The provider will submit to the department documentation the affiliate has completed a minimum of one thousand hours within thirty days of completion of the experience.

Affiliate:

- Represent him or herself as an affiliate only when performing clinical work supervised by the contracted provider.
- Maintain full documentation of the work done and supervision provided.

I certify the information included in this contract is accurate, and I have read and understand the requirements in [WAC 246-930-075](#) Supervision of affiliates.

Supervisor name (print) _____

Supervisor signature _____ Date _____
mm/dd/yyyy

Affiliate applicant name (print) _____

Affiliate applicant signature _____ Date _____
mm/dd/yyyy

Please send the completed contract to:

The Department of Health
Sex Offender Treatment Provider Credentialing
P.O. Box 47877
Olympia, Washington 98504-7877



Washington State Department of

Health

Sex Offender Treatment Provider Credentialing
 PO Box 47877
 Olympia, WA 98504-7877
 360.236.4700

Sex Offender Treatment Provider (SOTP) Supervised Experience Completion Verification

1. Applicant															
Name	First	Middle	Last												
Birth date (mm/dd/yyyy)		Affiliate Number													
Street Address															
City		State	Zip Code												
2. Supervisor (Provider)															
Supervisor Name			Phone Number												
Credential Number	Type of Credential(s)		First Issue Date												
Street Address															
City		State	Zip Code												
3. Supervised Experience (WAC 246-930-075)															
<p>Applicants must have a minimum of 2000 hours; at least 250 hours of treatment experience and 250 hours of evaluation experience. These hours must be verified by the provider with whom the affiliate has a signed and approved contract on file with the Department of Health. Please complete the actual months under your supervision.</p> <p>Dates applicant was supervised: from _____ to _____</p> <p>Please complete the actual hours under your supervision.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 70%;">Supervision</th> <th style="width: 30%;">Total Hours</th> </tr> </thead> <tbody> <tr> <td>Evaluation Experience (250 hours required).</td> <td></td> </tr> <tr> <td>Estimate of evaluation hours counted other than face to face with a client.</td> <td></td> </tr> <tr> <td>Treatment Experience (250 hours required).</td> <td></td> </tr> <tr> <td>Estimate of treatment hours counted maintaining collateral contacts and written case/progress notes.</td> <td></td> </tr> <tr> <td>Total number of supervised experience hours (2000 hours required).</td> <td></td> </tr> </tbody> </table>				Supervision	Total Hours	Evaluation Experience (250 hours required).		Estimate of evaluation hours counted other than face to face with a client.		Treatment Experience (250 hours required).		Estimate of treatment hours counted maintaining collateral contacts and written case/progress notes.		Total number of supervised experience hours (2000 hours required).	
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Estimate of treatment hours counted maintaining collateral contacts and written case/progress notes.															
Total number of supervised experience hours (2000 hours required).															
<p>Supervisor</p> <p>I certify the above information is, to the best of my knowledge, accurate and complete. I understand the department may request additional information, if it is needed, to evaluate the application of the individual named on this document. I also attest I have maintained an active SOTP and underlying credential during this time.</p> <p>Signature _____ Date _____</p> <p style="text-align: right; margin-right: 50px;">mm/dd/yyyy</p>															

Return this form to the address listed above.

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RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act.....	<u>UDA RCW 18.130</u>
Administrative Procedure Act	<u>APA RCW 34.05</u>
Administrative procedures and requirements	<u>WAC 246-12</u>
Sex Offender Treatment Providers RCW	<u>RCW 18.155</u>
Sex Offender Treatment Providers WAC.....	<u>WAC 246-930</u>

AIDS Courses

Health Impact	1.800.783.2437 or 206.284.3865
W.F. Professional.....	1.800.323.4305
AIDS Resources	206.784.5655

On-Line

AIDS Training	<u>Reference Page</u>
Sex Offender Treatment Provider.....	<u>Web Page</u>