



REINSTATEMENT INSTRUCTIONS **FOR CERTIFICATION OF SEX OFFENDER TREATMENT PROVIDERS**

Completed Application: The application must be notarized. To avoid delays, please provide a complete application packet. Incomplete packets will not be reviewed.

Application Fee: A fee of **\$125.00** is required for an application to be processed. All fees paid by check or money order must be made payable to the "Treasurer of Virginia". This fee is non-refundable. The application is valid for one year from date of receipt.

The below supplemental documentation must accompany your application and fee in one packet:

- Out-of-State Licensure/Certification Verification:** (If applicable) If you have ever held or hold a professional certification, licensure or registration in Virginia or any other jurisdiction, whether current or expired, you must submit a license verification/certification form. Please send the enclosed verification form to the issuing jurisdiction. This verification is to be completed by the issuing jurisdiction and mailed back to you and included in your application packet, **or** you can provide an online verification printed from your licensure jurisdiction website if the verification indicates that you have no disciplinary actions.
- Continuing Education (CE) Certificates:** Provide evidence of current ability to practice by submitting six (6) continuing education (CE) certificates from an approved provider or official transcript(s) showing credit hours in topics related to the provision of sex offender treatment for every year the certification was expired not to exceed a maximum of 24 CE hours.
- Name Change:** (If applicable) Documentation must be provided if your name has legally changed through marriage, divorce, or a court order. A photocopy of your marriage license or a copy of the court order must be provided.



Certified Sex Offender Treatment Provider Reinstatement Application

I hereby submit an application for reinstatement of my Virginia certification number _____.

Military/Military Spouse:

Are you active duty military personnel? Yes No

Are you the spouse of a member of the U.S. military who has been transferred to Virginia and who had to leave employment to accompany your spouse to Virginia? Yes No

<p>Complete All Sections</p> <p>Application Fee of \$125.00 is Non-Refundable</p> <p>Application forms lacking a Social Security or VA DMV number will not be processed.</p> <p>Mail all required documentation and fee to:</p> <p>Board of Psychology 9960 Mayland Dr., Suite 300, Henrico, Virginia 23233</p> <p>All signatures must be original.</p>	<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">Legal Name (First, Middle, Last)</div> <div style="display: flex; justify-content: space-between; margin-bottom: 5px;"> <div style="border: 1px solid black; padding: 5px; flex-grow: 1;">Other Names Used on Official Documents (i.e. transcripts)</div> <div style="border: 1px solid black; padding: 5px; text-align: center; width: 150px;">Sex (Circle) Male Female</div> </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">Public Address (Street/Box Number, City, State, Zip)</div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">Mailing Address (Street/Box Number, City, State, Zip) *</div> <div style="display: flex; justify-content: space-between; margin-bottom: 5px;"> <div style="border: 1px solid black; padding: 5px; flex-grow: 1;">Home Phone</div> <div style="border: 1px solid black; padding: 5px; flex-grow: 1;">Cell Phone</div> </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">Business Phone with extension</div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">Email</div> <div style="display: flex; justify-content: space-between; margin-bottom: 5px;"> <div style="border: 1px solid black; padding: 5px; flex-grow: 1;">Social Security Number (or VA DMV #)</div> <div style="border: 1px solid black; padding: 5px; flex-grow: 1;">Date of Birth</div> </div> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 5px;"> <thead> <tr> <th colspan="4" style="text-align: left; padding: 2px;">Education/Training (List in chronological order all graduate schools attended.)</th> </tr> <tr> <th style="width: 15%;">Degree Earned</th> <th style="width: 15%;">Date Degree Received</th> <th style="width: 30%;">Major</th> <th style="width: 40%;">Institution Name/State</th> </tr> </thead> <tbody> <tr> <td style="height: 20px;"> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td style="height: 20px;"> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table> <p style="font-size: small; margin-top: 5px;">* The address provided in this section is subject to disclosure under the Freedom of Information Act.</p>	Education/Training (List in chronological order all graduate schools attended.)				Degree Earned	Date Degree Received	Major	Institution Name/State								
Education/Training (List in chronological order all graduate schools attended.)																	
Degree Earned	Date Degree Received	Major	Institution Name/State														



Certified Sex Offender Treatment Provider Reinstatement Application – Page 2

Ethics Attestation: Please answer the six questions below. **If you answer yes to any question, include a detailed explanation or supporting documentation. Refer to Guidance Document 125-2 for detailed information on the requirements with a criminal conviction.**

- | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? If yes, please provide a full explanation. | Yes | No |
| (A) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? | Yes | No |
| 2. Have you ever been censored, warned, terminated, or requested to withdraw from your employment with any health care facility, agency, or practice? If yes, provide a full description of the circumstances and any supporting documentation. | Yes | No |
| 3. Within the past five years, have you been disciplined by any entity?
Please provide a full explanation and any associated orders or letters from the entity. | Yes | No |
| (A) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? | Yes | No |
| 4. Have you voluntarily surrendered your license, certification or registration while under investigation?
If yes, provide detail(s), jurisdiction(s), date(s), and supporting documentation. | Yes | No |
| 5. Have you ever been denied the issuance of a license, certification, or registration, or denied the privilege of taking an occupational examination by a licensing agency. If yes, provide detail(s), jurisdiction(s) and date(s). | Yes | No |
| 6. Have you ever been convicted of, pled Nolo Contendere to, or entered into a plea agreement for a violation of any federal, state or local statute, regulation, or ordinance?
(This includes convictions for driving under the influence, but does not include other traffic violations).
If yes, include an explanation of the charges/convictions, and attach documentation required in the Board's Guidance Document #125-2. | Yes | No |
| 7. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner?
"Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing psychologist. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.) | Yes | No |
| 8. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a sex offender treatment provider. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.) | Yes | No |
| 9. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a sex offender treatment provider. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.) | Yes | No |
| 10. Within the past 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? If yes, please provide a full explanation and any associated orders or letters from the entity. (NOTE: The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application, or have the program send this documentation directly to the Board.) | Yes | No |



Certified Sex Offender Treatment Provider Reinstatement Application – Page 3

Licenses / Certifications: List all mental health or health professional licenses or certificates that you hold or have ever held.

State	License #	Current License Status	Issue Date	Type of License

Attestation of Accuracy & Review of Virginia Regulations & Statutes: *By signing this document, I hereby certify that the information provided in this application is true, accurate and complete to the best of my knowledge and belief. I also certify that I have carefully reviewed and agree to apply the Statutes and Regulations Governing the Certification of Sex Offender Treatment Providers.*

Signature of Certificate Holder: _____

Date: _____



LICENSURE/CERTIFICATION VERIFICATION

Applicants for psychology licensure or certification in the Commonwealth of Virginia are required to send a licensure/certification verification form to **every** jurisdiction in which they currently hold, or have held, a license/certification to practice as a psychologist or any other health practitioner.

Name: _____ License Number: _____

Address: _____

TO BE COMPLETED BY STATE LICENSING/CERTIFYING BOARD
Please complete this form and return it directly to the applicant in a sealed envelope.

Title of License: _____ License Number: _____

Issue Date: _____ Expiration Date: _____

By Examination _____ By Endorsement _____ By Waiver _____ By Reciprocity _____

Type of Examination:

EPPP _____ Date of Examination: _____ Cut-Off Score _____ Applicant's Score _____

State Exam _____ Date: _____ Cut-Off Score _____ Applicant's Score _____

State Exam _____ Date: _____ Cut-Off Score _____ Applicant's Score _____

Has there ever been any disciplinary action taken against the license? [] Yes [] No If yes, give full particulars on a separate sheet.

Certification by the authorized Licensure Official of the State Board of _____

State of _____ Telephone Number (____) _____

I certify that the information is correct.

Authorized Licensure Official

Title

Jurisdiction/State

Date

SEAL