



REINSTATEMENT APPLICATION INSTRUCTIONS FOR CERTIFICATION AS A SEX OFFENDER TREATMENT PROVIDER (CSOTP)

IMPORTANT NOTICE:

Upon completion of the enclosed paper application for certification, you will be required to submit to the Virginia Board of Psychology the below supporting documentation with your application. Prior to **mailing** the enclosed application and below supporting documentation to the Board for consideration, we recommend that you review the [Regulations Governing the Certification of Sex Offender Treatment Providers](http://www.dhp.virginia.gov/psychology/) available on the Board's website at www.dhp.virginia.gov/psychology/ to ensure you are applying for the correct application type and have met the requirements for this application type. Pursuant to 18VAC125-30-20(B) of the [Regulations Governing the Certification of Sex Offender Treatment Provider](http://www.dhp.virginia.gov/psychology/), all fees submitted to the Board are **non-refundable**.

We also strongly encourage you to review your application packet to ensure all forms are complete and included. A complete application packet provides the best opportunity to avoid delays in the application review process. You should make every effort to mail all the below information in **one** complete packet to the Board office for consideration.

REQUIRED DOCUMENTATION

APPLICATION: The attached application must be completed and mailed to the Virginia Board of Psychology.

APPLICATION FEE: A **\$125.00** initial application fee by check, cashier's check or money order made payable to the **Treasurer of Virginia** must be mailed with your application. Your application will not be reviewed or considered until you have submitted payment. Pursuant to [18VAC125-30-20\(B\)](http://www.dhp.virginia.gov/psychology/), all fees submitted to the Board are **non-refundable**.

VERIFICATION OF LICENSURE/CERTIFICATION If applicable, provide license verification of all other health and mental health professional licenses, certificates, or registrations ever held in Virginia or any jurisdiction of the United States or Canada, **whether current or expired**. Please send the verification form to the issuing jurisdiction (s). This verification form should be completed by the issuing jurisdiction (s) and sent back to you and included in your application packet. *(Some jurisdictions charge a fee for this service. Check with that jurisdiction before sending the form. If the jurisdiction requires submitting this information directly to Virginia's Board office, please have them indicate your name on the form so that it can be included with your packet for evaluation.)* Alternatively, you can provide an online verification printed from the licensing jurisdiction's website if the online verification provides **all** of the following information: the licensee name, license number, license type, issue and expiration date, and whether disciplinary action has ever occurred.

CONTINUING EDUCATION (CE) CERTIFICATES:

Provide evidence of having met all applicable continuing competency requirements by providing 6 continuing education (CE) certificates from an approved provider or official transcript(s) in topics related to the provision of sex offender treatment for every year the license was expired not to exceed a maximum of 24 CE hours obtained within the four years immediately preceding application for reinstatement.

ADDITIONAL SUPPORTING DOCUMENTATION (if applicable)

PROOF OF NAME CHANGE: Documentation must be provided to show each name change(s) if your name has ever been legally changed from the time you attended school or other than what is listed on your application. Acceptable forms of documentation include a **photocopy** of a marriage license, court order or divorce decree.

CRIMINAL CONVICTIONS, PAST ACTIONS or POSSIBLE IMPAIRMENTS: If you answer "YES" to any of the questions in **Part IV** of the application, please include a detailed explanation **and** supporting documentation. *Please refer to [Guidance Document 125-2](#), available on the Board's website, for a list of required documentation that will be needed regarding criminal convictions, past actions, or possible impairments.*



GENERAL INFORMATION

- Applications are processed in the order received. Please allow adequate processing time for applications. Applications that are complete, fully documented and meet the minimum requirements for the [Regulations Governing the Certification of Sex Offender Treatment Providers](#) will be processed within **30 days** of receipt of a **complete** application packet.
- An incomplete application for licensure will be retained on file for one (1) year. After one year, all incomplete application files will be destroyed as outlined in the Library of Virginia records retention and disposition schedules.
- Application and required documentation should be **mailed** to:
Department of Health Professions
Attn: Board of Psychology
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233
- Pursuant to [Virginia Code § 54.1-116 \(A\)](#), you are required to submit your social security number or your control number issued by the *Virginia* Department of Motor Vehicles*. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided for by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities. **NO CERTIFICATION WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FAILED TO DISCLOSE ONE OF THESE NUMBERS.**

Read the Virginia Board of Psychology Regulations carefully for the requirements for certification as a [Sex Offender Treatment Provider](#).



REINSTATEMENT APPLICATION FOR CERTIFICATION AS A SEX OFFENDER TREATMENT PROVIDER (CSOTP)

TO BE COMPLETED BY APPLICANT

Part I. Applicant's Identification & Contact Information

Applicant's Last Name:	First Name:	Middle/Maiden Name:	Suffix:
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Social Security Number or Virginia DMV Control Number _____	Date of Birth: (MM/DD/YYYY) ____ / ____ / _____
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Published Address: *This address is subject to public disclosure under the Freedom of Information Act. You may provide an address other than a residence, such as a Post Office Box or practice location if you wish.*

Address:

City:	State:	Zip Code: _____
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Address of Record: *The address information you provide below is your address of record with the Board. Please be advised that all notices from the Board, to include certifications and other legal documents, will be sent to the address of record provided. If you provided a different public address above, this address is not subject to public disclosure under the Freedom of Information Act and will not be sold or distributed for any other purpose.*

Address:

City:	State:	Zip Code: _____
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Home Number: (____) _____ - _____	Alternate Number: (____) _____ - _____
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Email Address:

Part II. Education Information: *List in chronological order each graduate school or other institution where course work has been completed.*

Institution Name:	Type of Degree Received:	Date Graduated: ____ / ____ / _____
Institution Name:	Type of Degree Received:	Date Graduated: ____ / ____ / _____
Institution Name:	Type of Degree Received:	Date Graduated: ____ / ____ / _____

Part III. Licensure History Information: *List in order of attainment all the states in which you now hold or have ever held a health or mental health license or certification, whether current or expired. If not applicable, enter N/A*

State	Type of License/Certificate	License/Certificate Number	Issued Date	Current Status



Part IV. Registration Questions: Applicants must answer the following questions. Affirmative responses to any questions on this application will require additional information to be submitted. Please refer to [Guidance Document 125-2](#) for a list of required documentation that will be needed regarding criminal convictions, past actions, or possible impairments. Failure to disclose any information related to these questions may be grounds for denial, reprimand, or imposition of terms, suspension or revocation of your license and/or registration.

<p>1. Have you been disciplined by any entity related to your work in health or mental health setting? If Yes, on a separate sheet of paper provide a full detailed explanation and any associated orders or letters from the entity.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2. Are you the respondent in any pending or unresolved Board action in another jurisdiction or in a malpractice claim? If Yes, on a separate sheet of paper please provide a full detailed explanation.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>3. Have you ever been denied the privilege of taking an occupational licensure, certification or registration examination? If Yes, on a separate sheet of paper please provide a full detailed explanation that includes what type of occupational examination, where (jurisdiction), when (dates) and why denied.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>4. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients or clients? If Yes, on a separate sheet of paper please provide a full detailed explanation. Note: the Board may ask for additional documentation.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>5. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? If No, on a separate sheet of paper please provide a full detailed explanation. Note: the Board may ask for additional documentation.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>6. Have you ever been censured, warned, terminated, or requested to withdraw from your employment with any health care facility, agency or practice? If Yes, please provide a full description of the circumstances and any supporting documentation.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>7. 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 detailed explanation.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>8. Have you ever been convicted, pled guilty to or pled Nolo Contendere to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor? (Including convictions for driving under the influence, but excluding traffic violations). Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, does not have to be disclosed. If Yes, on a separate sheet of paper please provide a full detailed explanation that includes what type of occupational examination, where (jurisdiction), when (dates) and why denied and attach documents referenced in Guidance Document 125-2.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>9. Have you voluntarily surrendered your license, certification or registration while under investigation? If Yes, please provide detail(s), jurisdiction(s), date(s), and supporting documentation.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>10. 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.)</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Part V. Military Service</p>	
<p>1. Are you a spouse of someone who is on federal active duty orders pursuant to Title 10 of the U. S. Code or of a veteran who has left active-duty service within one year of submission of this application and who is accompanying your spouse to Virginia or an adjoining state or the District of Columbia?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2. Are you active-duty military?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



Virginia Department of
Health Professions
 Board of Psychology

9960 Mayland Drive, Suite 300
 Henrico, VA 23233-1463
www.dhp.virginia.gov/psychology

Email: psy@dhp.virginia.gov
 (804) 367-4697 (Tel)
 (804) 767-3626 (Fax)

Part VI. Certification: *This application is not valid unless properly certified by your original signature.*

I certify by my signature below that I am the person applying for certification and meet the qualifications required by Virginia laws and regulations. I certify by my signature that I have carefully read the laws and Regulations Governing the Certification of Sex Offender Treatment Providers in the Commonwealth of Virginia, which are available at <https://www.dhp.virginia.gov/Psychology/>.

Further, I certify by my signature below that the information provided on this application has been personally provided and reviewed by me, and that statements made on the application are true and complete. I understand that providing false or misleading information, as well as omitting information, in response to information required in this application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing license/certificate/registration.

I agree to the above certification.

SIGNATURE:	DATE:
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ORIGINAL SIGNATURE REQUIRED