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)

APPLICATION INSTRUCTIONS FOR INITIAL REGISTRATION OF SUPERVISION TOWARD A CERTIFIED SEX OFFENDER TREATMENT PROVIDER (CSOTP)

IMPORTANT NOTICE:
Upon completion of the enclosed paper application for initial registration of supervision, 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 available on the Board's website at www.dhp.virginia.gove/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 Providers, 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. *Only one (1) supervisor can be registered with this application. An Add/Change of Registration of Supervision application, fee and supporting documentation must be submitted for **each** addition or change in supervisor.*

☐ **APPLICATION FEE**: A **$50.00** 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), all fees submitted to the Board are **non-refundable**.

☐ **OFFICIAL TRANSCRIPT**: An official graduate transcript (paper or electronic) is required. The transcript must be included in your application packet **or** emailed electronically directly to the Board at psy@dhp.virginia.gov via a secured electronic transcript service used by the school (for example: eScript or parchment). **Photocopied transcripts will not be accepted. All official transcripts must include a conferred date.**

☐ **SUPERVISORY CONTRACT:** Signed contract that outlines the expectations and responsibilities of the supervisor and trainee in accordance with the regulations of the Board is required. (Supervisory contract example can be found on the Board's website)

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.

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- 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 FALIED TO DISCLOSE ONE OF THESE NUMBERS.
- Supervision should include at least one hour of face-to-face supervision per 20 hours of experience for a total of at least 100 hours. Group supervision involving up to six members in a group will be acceptable for a maximum of 50 hours.
- At least 2,000 hours of post-degree clinical experience in the delivery of clinical assessment/treatment services. At least 200 hours of this experience must be face-to-face treatment and assessment with sex offender clients.

Supervised work experience occurring in Virginia, in any setting, must be registered and approved by the Board prior to beginning that supervision. An applicant may not count hours towards certification unless that supervised experience has been registered with the Board.

Read the Virginia Board of Psychology Regulations carefully for the requirements for certification as a Sex Offender Treatment Provider.

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INTITIAL REGISTRATION OF SUPERVISION APPLICATION TOWARD A CERTIFIED SEX OFFENDER TREATMENT PROVIDERS (CSOTP)

TO BE COMPLETED BY APPLICANT/TRAINEE

Part I. Trainee's Identification & Contact Information

Trainee's Last Name:	First Name:	Middle/Maiden Name:	Suffix:

Social Security Number or Virginia DMV Control Number	Date of Birth: (MM/DD/YYYY)
___ ___ ___ ___ ___ ___ ___ ___ ___	___ ___ / ___ ___ / ___ ___ ___ ___

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:
		___ ___ ___ ___ ___

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:
		___ ___ ___ ___ ___

Home Number:	Alternate Number:
(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Email Address:

Part II. Proposed Supervisor & Worksite Location Information

A. Proposed Supervisor's Information

Supervisor's Last Name:	First Name:	Supervisor's Email:

Does your proposed supervisor hold current and unrestricted Virginia license as a clinical nurse specialist, doctor of medicine or osteopathic medicine, professional counselor, clinical social worker, or clinical psychologist **and** hold a current CSOTP Certification?	☐ Yes ☐ No

Supervisor's License Number:

___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Supervisor's CSOTP Certification Number:

___ ___ ___ ___ ___ ___ ___ ___ ___ ___

B. Proposed Worksite Information *(location where you, the trainee will complete hours of supervised post-degree clinical experience in the delivery of clinical assessment/treatment services toward certification as a CSOTP)*

Name of Proposed Worksite: (Name and complete address)

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Part III. 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 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.*

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.***	☐ Yes ☐ No
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.***	☐ Yes ☐ No
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.***	☐ Yes ☐ No
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.***	☐ Yes ☐ No
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.***	☐ Yes ☐ No
6. Have you ever been censored, 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.***	☐ Yes ☐ No
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.***	☐ Yes ☐ No
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.*	☐ Yes ☐ No
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.***	☐ Yes ☐ No
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.) If Yes, on a separate***	☐ Yes ☐ No

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Part V. Military Service

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?	☐ Yes ☐ No
2. Are you active-duty military?	☐ Yes ☐ No

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 registration 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:**

ORIGINAL SIGNATURE REQUIRED