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)

VERIFICATION of POST-DEGREE SUPERVISION for CERTIFIED SEX OFFENDER TREATMENT PROVIDER (CSOTP)

IMPORTANT NOTICE:
The applicant should complete the top portion of this form **only**, then provide this form to the supervisor who supervised the applicant's post-degree experience. The completed form containing the original signature of the supervisor, should be returned to the applicant for inclusion in their application packet that must be mailed to the Virginia Board of Psychology. **If supervision took place under more than one supervisor, a separate form is required for each.**

TO BE COMPLETED BY APPLICANT/TRAINEE

Last Name:	First Name:	Middle/Maiden Name:	Suffix:

Email Address:	Last 4 digits of Social Security Number: XXX-XX- _____ _____ _____ _____

TO BE COMPLETED BY SUPERVISOR:

Part I: Supervisor's Information

Last Name:	First Name:	Middle/Maiden Name:	Suffix:

Email Address:	Supervisor's Phone Number:
CSTOP Certification Number:	License Number:

Part II: Worksite Information *(location where supervisee obtained post-master's degree experience)*

Name of Worksite:		
Address of Worksite:		
City:	State:	Zip Code: _____ _____ _____ _____ _____

Part III: Dates of Supervision

Start Date: (MM/DD/YYYY)	End Date: (MM/DD/YYYY)
____ ____ / ____ ____ / ____ ____ ____ ____	____ ____ / ____ ____ / ____ ____ ____ ____

Part IV: Hours & Competencies *(Answers to the below questions should be provided based on the supervision obtained under the instructions of the supervisor completing this form. If the response is "NO" to any of the below questions, please provide an explanation on a separate sheet of paper and provide it with this form to the applicant.)*

a. Did the applicant receive a minimum of one (1) hour of face-to-face supervision for every 20 hours of experience?	☐ **YES**	☐ **NO**
b. How many hours of **individual** face-to-face supervision hours did the applicant receive?		
c. How many hours of **group** face-to-face supervision did the applicant receive?		
d. Did the applicant complete a minimum of **2,000 hours** of supervised post-degree experience in the delivery of clinical assessment/treatment services with at least **200 hours** of this experience in face-to-face treatment and assessment with sex offender clients while under your direct supervision?	☐ **YES** *Exact # of Hours Received* _____	☐ **NO** *If not, how many hours* _____

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e. Did the applicant demonstrate minimum competencies of **sex offender assessment** while under your direct supervision?	☐ **YES**	☐ **NO**
f. Did the applicant demonstrate minimum competencies of **sex offender treatment interventions** while under your direct supervision?	☐ **YES**	☐ **NO**
g. Did the applicant demonstrate minimum competencies of **etiology/development issues of sex offense behavior** while under your direct supervision?	☐ **YES**	☐ **NO**
h. Did the applicant demonstrate minimum competencies of **criminal justice and legal issues related to sexual offending** while under your direct supervision?	☐ **YES**	☐ **NO**
i. Did the applicant demonstrate minimum competencies of **treatment effectiveness and issues related to relapse prevention or recidivism of sex offenders** while under your direct supervision?	☐ **YES**	☐ **NO**
j. In your opinion has the applicant demonstrated competency in providing sex offender treatment services?	☐ **YES**	☐ **NO**
k. In your opinion does the applicant need any additional supervision or training prior to being certified as a sex offender treatment provider?	☐ **YES**	☐ **NO**

Part V: Declaration of Supervisor

I, _____ (name of supervisor) declare by my signature, to the best of my knowledge the foregoing is true and correct.

_____ _____

Signature of Supervisor Date