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 CERTIFICATION AS A SEX OFFENDER TREATMENT PROVIDER

REQUIRED DOCUMENTATION

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

☐ **APPLICATION FEE**: A **$90.00** 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.** *If you have been previously approved by the Board for supervision, a duplicate transcript is not required.*

☐ **TRAINING VERIFICATION**: In addition to the form, official school transcript(s) or certificates of completion must be submitted to verify completion of a minimum of 50 clock hours of training in sex offender treatment.

☐ **REFERENCE LETTERS**: Include reference letters from three licensed health care professionals who can attest to your skills and experience in sex offender treatment.

☐ **VERIFICATION OF SUPERVISION**: The Verification of Supervision form should be completed by your supervisor, verifying hours obtained during your clinical experience.

- The board may waive the registration of supervision requirement for individuals who have obtained at least five years documented work experience in sex offender treatment in another jurisdiction. Please submit documentation if this applies.
- The board will also credit hours obtained as part of any post-degree clinical experience for a mental health license within the past 10 years if:
  - a. The applicant documents that the hours were in the treatment and assessment with sex offender clients; and
  - b. The supervisor for those hours attests that they were licensed and qualified to render services to sex offender clients at the time of the supervision.

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.

☐ **VERIFICATION OF LICENSURE/CERTIFICATION:** If you have ever held a health or mental health license or certification, whether current or expired, please send the enclosed verification form to the issuing jurisdiction (s). This verification is to be completed by the issuing jurisdiction (s) and mailed 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.)* **–or-** You can provide an online verification printed from the licensing jurisdiction's website if the online verification

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provides **all** of the following information; the licensee name, license number, license type, issue and expiration date, and whether disciplinary action has ever occurred.

☐ **VERIFICATION OF OUT-OF-STATE SUPERVISOR LICENSURE:** If your supervision did not take place in Virginia, you must submit verification of your supervisor's license. You may submit an online Verifications printed form the issuing license jurisdiction website or you may submit the enclosed verification form.

☐ **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. If not completed within one year of receipt, a new application and fee will be necessary.

- 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.

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

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APPLIATION FOR CERTIFICATION AS A SEX OFFENDER TREATMENT PROVIDER

TO BE COMPLETED BY APPLICANT

Part I. Applicant's Identification & Contact Information

Applicant'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. 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

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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 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 and attach documents referenced in Guidance Document 125-2.***	☐ 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, on a separate sheet of paper please provide a full detailed explanation.***	☐ Yes ☐ No
3. 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) ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 125-2.***	☐ Yes ☐ No
4. Have you ever voluntarily surrendered a license, certification or registration while under investigation? ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 125-2.***	☐ Yes ☐ No
5. 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
Additional Questions	
1. **A**. 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, on a separate sheet of paper please provide a full detailed explanation*** **B**. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 125-2.***	☐ Yes ☐ No ☐ Yes ☐ No
2. **A**. Within the past five years, have you been disciplined by any entity? ***If Yes, on a separate sheet of paper please provide a full detailed explanation*** **B**. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 125-2.***	☐ Yes ☐ No ☐ Yes ☐ No
3. 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 sex offender treatment provider or trainee.* ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 125-2.***	☐ Yes ☐ No
4. 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 practicing sex offender treatment provider or trainee.* ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 125-2.***	☐ Yes ☐ No
5. 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 practicing sex offender treatment provider or trainee.* ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 125-2.***	☐ Yes ☐ No

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6. Within the past five years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 125-2.***	☐ Yes ☐ No
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 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:**

ORIGINAL SIGNATURE REQUIRED

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VERIFICATION OF TRAINING

TO BE COMPLETED BY APPLICANT:			
Last Name:	First Name:	Middle/Maiden Name:	Suffix:
Email Address:	Last 4 digits of Social Security Number: XXX-XX- _____ _____ _____ _____		

Part I: Provided evidence of completing 50 clock hours of training in sex offender treatment acceptable to the Board in the below areas. In addition to the form, official school transcript(s) or certificates of completion must be submitted to the Board.

Content Area	Course Title	Clock Hours	Provider
Sex Offender Assessment **(minimum of 15 clock hours)**			
Sex Offender Treatment Interventions **(minimum of 15 clock hours)**			
Etiology/Developmental Issues of Sex Offense Behavior **(minimum of 10 clock hours)**			
Criminal Justice and Legal Issues Related to Sexual Offending **(minimum of 5 clock hours)**			
Program Evaluation, Treatment Efficacy, and Issues Related to Recidivism of Sex Offenders **(minimum of 5 clock hours)**			

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VERIFICATION of POST-DEGREE SUPERVISION

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 six (6) hours per month of face-to-face supervision?	☐ **YES** *Exact # of Hours Received* _____	☐ **NO** *If not, how many hours* _____
b. Did the applicant complete a minimum of 2,000 hours of supervised post-degree experience in the delivery of clinical assessment/treatment services while under your direct supervision?	☐ **YES** *Exact # of Hours Received* _____	☐ **NO** *If not, how many hours* _____
c. How many hours of **individual** face-to-face supervision hours did the applicant receive?		
d. How many hours of **group** face-to-face supervision did the applicant receive?		

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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 **program evaluation, treatment efficacy and issues related to 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

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APPLICANT OUT-OF-STATE LICENSURE VERIFICATION

IMPORTANT NOTICE:
This form must be completed by both the applicant and the jurisdiction/State Board that issued the applicant a health or mental health license or certification. **The Applicant should complete Part I of this form ONLY.** The State Board should complete Part II of this form. The completed form should be returned to the applicant for inclusion in their application packet to be mailed to the Virginia Board of Psychology or the State Board can send the form electronically to the Virginia Board at psy@dhp.virginia.gov

TO BE COMPLETED BY APPLICANT: Complete the top portion **only** and send this form to the jurisdiction (s)/State Board (s) that issued you a health or mental health license or certification **(fee may be required)**.

Part I. Applicant's Identification & Contact Information

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

Last 4 digit of Social Security Number: XXX-XX- ___ ___ ___ ___	Date of Birth: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___

Address:

City:	State:	Zip Code: ___ ___ ___ ___ ___

Email Address:

TO BE COMPLETED BY STATE BOARD: Please provide official verification of applicant's licensure/certification information requested below and mail or email completed form to applicant or **directly** to the Virginia Board of Psychology. **If emailing this form to the Virginia Board, please use the subject line: Applicant Licensure Verification *(ref: Applicant's Name)***

Part II. Applicant's Licensure Information

Title of License:	License Number:
Issue Date: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___	Expiration Date: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___

License Obtained by:
☐ Examination ☐ Endorsement ☐ Reciprocity ☐ Grandfathered ☐ other _____

Status of License:
☐ Current ☐ Lapsed ☐ Inactive ☐ other _____

Has license ever been denied, suspended, revoked, placed on probation or otherwise disciplined? ***If yes, please attach certified copy of order issued by State Board.***	YES ☐ NO ☐

I certify the above information to be true in every respect, according to the record on file with the

_____ *(Title of Board)*

Name of Authorized Licensure Official: _____

Title of Authorized Licensure Official: _____

STATE SEAL

Telephone Number: _____

Email Address: _____

Date: _____

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APPLICANT OUT-OF-STATE SUPERVISOR LICENSURE VERIFICATION

IMPORTANT NOTICE:
This form must be completed by both the applicant and the jurisdiction/State Board that issued the applicant's supervisor health or mental health license or certification. **The Applicant should complete Part I & II of this form ONLY.** The State Board should complete Part III of this form. The completed form should be returned to the applicant for inclusion in their application packet to be mailed to the Virginia Board of Psychology or the State Board can send the form electronically to the Virginia Board at psy@dhp.virginia.gov

TO BE COMPLETED BY APPLICANT: Complete **Parts I & II only** and send this form to the jurisdiction (s)/State Board (s) that issued you a health or mental health license or certification **(fee may be required)**.

Part I. Applicant's Identification & Contact Information

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

Last 4 digit of Social Security Number: XXX-XX- ___ ___ ___ ___	Date of Birth: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___

Address:

City:	State:	Zip Code: ___ ___ ___ ___ ___

Email Address:

Part II. (Supervisor's Information to be verified)

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

TO BE COMPLETED BY STATE BOARD: Please provide official verification of applicant's supervisor licensure/certification information requested below and mail or email completed form to applicant or **directly** to the Virginia Board of Psychology. **If emailing this form to the Virginia Board, please use the subject line: Supervisor Licensure Verification *(ref: Applicant's Name)***

Part III. Supervisor's Licensure Information

Title of License:	License Number:
Issue Date: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___	Expiration Date: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___

Status of License:
☐ Current ☐ Lapsed ☐ Inactive ☐ other _____

Has license ever been denied, suspended, revoked, placed on probation or otherwise disciplined? ***If yes, please attach certified copy of order issued by State Board.***	YES ☐ NO ☐

I certify the above information to be true in every respect, according to the record on file with the

_____ *(Title of Board)*

Name of Authorized Licensure Official: _____

Title of Authorized Licensure Official: _____

STATE SEAL

Telephone Number: _____

Email Address: _____

Date: _____