



REINSTATEMENT APPLICATION INSTRUCTIONS CERTIFIED SEX OFFENDER TREATMENT PROVIDER (CSOTP)

This application is for individuals whose Sex Offender Treatment Provider certification has not been renewed in over one (1) year and wishes to resume practicing as a CSOTP in Virginia.

APPLICATION INSTRUCTIONS

Follow these steps to apply for Reinstatement of your Sex Offender Treatment Provider certification:

1. **Review** the Laws and Regulations regarding the Certification of Sex Offender Treatment Providers in Virginia to ensure you are applying for the correct application type and have met the requirements for this application type. **Application fees are non-refundable.**
2. **Gather and Request** ALL the necessary documents in the checklist.
 - o Ensure you have included all the necessary documents as indicated by the checklist. A complete application provides the best opportunity to avoid delays in the review and approval process.
 - o It is preferred that you mail necessary documents in **one** complete packet to the Board office.
3. **Mail** the application, non-refundable fee, and required documentation to:

Department of Health Professions
Attn: Board of Psychology
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233

4. **Wait** for the Board to review your application and reply to any correspondence from the Board.
 - o Applications that are complete, fully documented and meet the minimum requirements for the Regulations Governing the Certification of Sex Offender Treatment Providers will be reviewed within **30 days** of receipt of a **complete** application.
 - o Incomplete applications remain active for one year from the date of payment, after which incomplete application files are destroyed as outlined in the Library of Virginia records retention and disposition schedules. If your application is not completed in the one-year timeframe, you are required to re-apply by submitting a new application, fee, and documentation pursuant to the regulations at that time.
 - o Your online checklist will be your primary source of application status.
 - o As documentation is received and reviewed, your checklist will be updated, and an automated email will be sent to you 24 hour later.

RULES AND GUIDELINES

- Please notify the Board in writing within 30 days of a name change or address change by completing the **Name/Address Change Form**.
- Providing false or misleading information as well as omitting information in response to information requested in the 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 registration, certification, or license.
- Pursuant to Virginia Code § 54.1-2400.02 addresses of sex offender treatment providers are made available to the public. Normally, the Address of Record is the publicly disclosed address. If you do not want your Address of Record to be made public, you may provide a second, publicly disclosable address (e.g. work or practice address). If you would like your Address of Record to be publicly available, please complete both sections with same address on the application.
- 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 license will be issued to any individual who has failed to disclose one of these numbers.**

REINSTATEMENT APPLICATION CHECKLIST

CHECK	REQUIRED DOCUMENTATION	SUBMIT BY
Required	1. APPLICATION	
<input type="checkbox"/>	The attached Reinstatement Application must be completed and <u>mailed</u> to the Virginia Board of Psychology.	Mail
Required	2. APPLICATION FEE	
<input type="checkbox"/>	<p>A \$125.00 application fee is required with your Reinstatement Application.</p> <ul style="list-style-type: none"> The fee must be in the form of a check, cashier's check, or money order made payable to the "Treasurer of Virginia". Your application will not be reviewed until you have submitted payment. All fees submitted to the Board are non-refundable. 	Mail
Required	3. CONTINUING EDUCATION (CE) CERTIFICATES	
<input type="checkbox"/>	<p>Provide copies of your continuing education certifications or official transcripts as evidence of having met all applicable continuing competency requirements for reinstatement. For every year your certification was expired, not to exceed four (4) years, you must complete:</p> <ul style="list-style-type: none"> 6 hours of continuing education courses Must be in topics related to the provision of sex offender treatment from an approved provider or official transcript(s) showing credit hours. 	Mail
If Applicable	4. OUT-OF-STATE LICENSE VERIFICATION	
<input type="checkbox"/>	<p>If you have ever held, or currently hold, a health or mental health license, certification, or registration, whether current, inactive, or expired, you must submit proof of licensure verification.</p> <ul style="list-style-type: none"> If the licensing jurisdiction provides online license verification, you can provide documentation printed directly from the jurisdiction's website. The verification must include the following information: <ul style="list-style-type: none"> Licensee name, License number, License type, Issue date, Expiration date, and whether disciplinary action has ever occurred against your license, certification, or registration. If the jurisdiction does not provide online verification, you must contact the jurisdiction directly to obtain license verification. Please see the Board's Applicant Out-of-State Licensure Verification form. 	Mail
If Applicable	5. PROOF OF NAME CHANGE	
<input type="checkbox"/>	You must provide documentation if your name has ever been legally changed from the time you were licensed, certified, or registered in Virginia. Acceptable forms of documentation are copies of a marriage certificate, court order, or divorce decree.	Mail
If Applicable	6. CRIMINAL CONVICTIONS, PAST ACTIONS OR POSSIBLE IMPAIRMENTS	
<input type="checkbox"/>	If you answer "YES" to any of the questions on the criminal convictions, past actions, or possible impairment questions on the application, you must include a detailed explanation and supporting documentation. Please refer to Guidance Document 125-2 , for a list of required documentation and further information. All applications are reviewed on a case-by-case basis.	Mail

End of Instructions



REINSTATEMENT APPLICATION CERTIFIED SEX OFFENDER TREATMENT PROVIDER (CSOTP)

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) ____ / ____ / ____	

CSOTP Certification Number (10-digit number): _____

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.

Street 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 Published Address above, the Address of Record is not subject to public disclosure under the Freedom of Information Act and will not be sold or distributed for any other purpose.

Street Address:

City:	State:	Zip Code:

Home Number:	Alternate Number:
(____) _____ - _____	(____) _____ - _____

Email Address:

Part II. Licensure History Information

List in order of attainment all the states in which you currently hold, or have ever held, a health or mental health license, certification, or registration, whether current, inactive, or expired.

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

Part III. Registration Questions

Applicant 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 additional information 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. Please use a separate sheet of paper to provide detailed explanations as required.

1. Have you ever been denied the privilege of taking an occupational licensure, certification, or registration examination? <i>If Yes, please state what type of occupational examination, where (jurisdiction), when (dates) and why denied.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been censored, warned, terminated, or requested to withdraw from your employment with any health care facility, agency, or practice? <i>If Yes, please explain in detail and provide supporting documentation to the Board.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> 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). 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. <i>If Yes, please explain in detail and provide supporting documentation to the Board.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you voluntarily surrendered your license, certification, or registration while under investigation? <i>If Yes, please explain in detail and provide supporting documentation to the Board.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you the respondent in any pending or unresolved Board action in another jurisdiction or in a malpractice claim? <i>If Yes, please explain in detail and provide supporting documentation to the Board.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients or clients? <i>If Yes, please provide a full detailed explanation. Note: the Board may ask for additional documentation.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? <i>If No, please provide a full detailed explanation. Note: the Board may ask for additional documentation.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Within the past five (5) years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? <i>If Yes, please provide a full explanation.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you been disciplined by any entity related to your work in a health or mental health setting? <i>If Yes, please provide a full explanation and any associated orders or letters from the entity.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity. <i>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.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Part IV. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you active-duty military?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Part V. Certification	
This application is not valid unless properly certified by your wet/original or verifiable electronic signature.	
<p>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/Boards/Psychology/ and agree to comply with the current Standards of Practice and laws governing the practice of psychology in Virginia.</p> <p>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.</p> <p>I agree to the above certification.</p>	
SIGNATURE:	DATE:

Wet/Original or Verifiable Electronic Signature Only