Virginia Department of Health Professions
Board of Psychology

Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Email: psy@dhp.virginia.gov
Phone: (804) 367-4697 **E-Fax:** (804) 767-3626
www.dhp.virginia.gov/Boards/Psychology/

INITIAL TRAINEE REGISTRATION as a SEX OFFENDER TREATMENT PROVIDER
Paper Application Checklist Instructions

This application is for individuals who have completed the educational requirements in 18VAC125-30-40 and who need to start their supervised experience toward certification as a Sex Offender Treatment Provider.

APPLICATION INSTRUCTIONS

Follow these steps to apply for Initial Registration:

1. **Read** the Laws regarding the Practice of Psychology and the Regulations Governing the Certification of Sex Offender Treatment Providers in Virginia and utilize the detailed information in the Sex Offender Treatment Provider Certification Process Handbook for detailed information about the required documents and process to obtain a license.
2. **Gather and Request** ALL the necessary documents in the checklist BEFORE submitting your application. A complete application provides the best opportunity to avoid delays in the review and approval process.
3. **Complete** the enclosed application form.
4. **Mail** the completed application form, **non-refundable** application fee, and all necessary documents to:

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

5. **Wait** for Board review of your application and reply to any correspondence from the Board.
   - 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.
   - 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.
   - Your online checklist will be your primary source of application status.
   - As documentation is received and reviewed, your checklist will be updated, and an automated email will be sent to you 24 hours later.

RULES AND GUIDELINES

- Supervised experience obtained in Virginia without prior written Board approval will not be accepted toward certification.
- 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 trainees 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.***

INITIAL REGISTRATION APPLICATION CHECKLIST

Check	REQUIRED DOCUMENTATION
Required	**1. APPLICATION**
☐	The enclosed application must be completed and mailed to the Virginia Board of Psychology along with the application fee and required documentation from this checklist.
Required	**2. APPLICATION FEE**
☐	A **$50.00** application fee is required with your Initial Trainee Registration Application as a Sex Offender Treatment Provider. • 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**.
Required	**3. OFFICIAL SCHOOL TRANSCRIPT**
☐	Request that copies of your official college transcripts be mailed or emailed directly to the Board from your school. • The transcripts must show that you graduated with a master's or doctoral degree in social work, psychology, counseling, or nursing from a regionally accredited university, or hold the degree of Doctor of Medicine or Doctor of Osteopathic Medicine from an institution that is approved by an accrediting agency recognized by the Virginia Board of Medicine. The transcript must contain your conferred date. • It is encouraged that transcripts be electronically sent directly to the Board at psy@dhp.virginia.gov via a secured electronic transcript service used by the school (for example: eScript or Parchment). • If your school is unable to send your transcripts electronically, the official transcripts can be mailed to the Board. • Photocopied transcripts will not be accepted.
Required	**4. SUPERVISORY CONTRACT**
☐	Submit a copy of the signed contract between you and your supervisor outlining the expectations and responsibilities during your Board approved supervised experience. A sample supervisory contract to use as a template is available on the Board's website.
If Applicable	**5. PROOF OF NAME CHANGE**
☐	You must provide documentation if your name has ever been legally changed from the time you attended school or were licensed, certified, or registered in another jurisdiction or is other than what is listed on your application. Acceptable forms of documentation are copies of a marriage certificate, court order, or divorce decree.
If Applicable	**6. CRIMINAL CONVICTIONS, PAST ACTIONS or POSSIBLE IMPAIRMENTS**
☐	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.

End of Instructions

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INITIAL TRAINEE REGISTRATION as a SEX OFFENDER TREATMENT PROVIDER
Paper Application

Part I. Applicant 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.

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 licenses 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. 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, certification or registration, whether current or expired.

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

First Name: _____ Last Name: _____

Part IV. Proposed Supervisor & Worksite Location Information

A. Proposed Supervisor Information

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

Does your supervisor hold a current and unrestricted Virginia license as a clinical nurse specialist, doctor of medicine or osteopathic medicine, professional counselor, marriage and family therapist, clinical social worker, or clinical psychologist AND hold a current CSOTP Certification?	☐ Yes ☐ No
Supervisor's Virginia License Number (10 Digit Number): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	
Supervisor's CSOTP Certification Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	

B. Proposed Worksite Information. Location where you, the applicant will complete you supervised experience toward certification.

Name of Proposed Worksite:			
Worksite Street Address:	Worksite City:	Worksite State:	Worksite Zip Code:

Part V. Licensure 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 are required.

1. Have you ever been denied the privilege of taking an occupational licensure, certification, or registration examination? *If Yes, please state what type of occupational examination, where (jurisdiction), when (dates) and why denied.*	☐ 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, please explain in detail and provide supporting documentation to the Board.*	☐ 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). 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, please explain in detail and provide supporting documentation to the Board.*	☐ Yes ☐ No
4. Have you voluntarily surrendered your license, certification, or registration while under investigation? *If Yes, please explain in detail and provide supporting documentation to the Board.*	☐ Yes ☐ No
5. Are you the respondent in any pending or unresolved Board action in another jurisdiction or in a malpractice claim? *If Yes, please explain in detail and provide supporting documentation to the Board.*	☐ Yes ☐ 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? *If Yes, please provide a full detailed explanation. Note: the Board may ask for additional documentation.*	☐ Yes ☐ No
7. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? *If No, please provide a full detailed explanation. Note: the Board may ask for additional documentation.*	☐ Yes ☐ 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? *If Yes, please provide a full explanation.*	☐ Yes ☐ No

First Name: _____ Last Name: _____

9. **Have you been disciplined by any entity related to your work in a health or mental health setting?** *If Yes, please provide a full explanation and any associated orders or letters from the entity.*	☐ 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.)*	☐ Yes ☐ No

Part VI. 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 VII. Certification:

This application is not valid unless properly certified by your wet/original or verifiable electronic 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/Boards/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:**

Wet/Original or Verifiable Electronic Signature Only