Sex Offender Treatment Provider License Application Packet

Contents:

Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. 42 U.S.C. § 666(a)(13); RCW 26.23.150. It will be used under the state's child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you have questions.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Sex Offender Treatment Provider Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms.

☐ **Application Fee**. This fee is non-refundable. You can check the online **fee page** for current fees.

☐ **Select if the following applies:**
Spouse or Registered Domestic Partner of Military Personnel

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you do not have one.
National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See **WAC 246-12-310**.

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **2. Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Experience:**
List in date order all your professional experience and practice from date of graduation from professional college. Attach additional pages if you need more space.

☐ **4. Education:**
List in date order list your educational preparation and post-graduate training. Attach additional pages if you need more space.

☐ **5: Other License, Certification, or Registration:**
List all states where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. Attach additional pages if you need more space.

☐ **6: Affiliate Applicants:**
Provide name, address and telephone number of your supervisor you will be using when working with clients.

☐ **7: Applicant's Attestation:**
You must sign and date this for us to process the application.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and

are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

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License Requirements

Sex Offender Treatment Provider License Requirements

To qualify for licensing in Washington as a **Sex Offender Treatment Provider**, an applicant must:

- ☐ Complete and submit the application, with a original signature, date, and **fee**.
- ☐ **Education:**
  Provide your education history, which must include a minimum of a master's degree from a recognized institution of higher learning. Provide official transcripts with degree and date posted.
- ☐ **Professional Experience:**
  Complete the **Supervised Experience Verification form** providing a detailed description of all experience to include hours acquired and calculated face-to-face treatment and evaluation hours.

  OR

  Complete the **Attestation of Qualification Based on Experience** and submit the **Qualified Supervisor Attestation** signed by your supervisor.
- ☐ **Work History and Experience:**
  List your professional experience and work history from the date of completion from your education.
- ☐ **Examination:**
  Once all required documents have been received, you will be sent a Washington State law examination provided by the department.
- ☐ **Underlying License (RCW 18.155.020):**
  A certified sex offender treatment provider means an individual who is a licensed psychologist, license marriage and family therapist, licensed social worker, licensed mental health counselor, or psychiatrist as defined in **RCW 71.05.020**. All applicants are required to hold a licensel in Washington or a state or jurisdiction other than Washington. This underlying license must be maintained in good standing.
- ☐ Completion of the **signed statement form**. To be completed if your underlying license is in a state or jurisdiction other than Washington.
- ☐ Completion of the **Request for Professional Training and References**.
- ☐ Out-of-State credential Verification must be received from every state where you hold or have held a healthcare practitioner credential.

Sex Offender Treatment Provider Affiliate License Requirements

To qualify for licensing in Washington as a **Sex Offender Treatment Provider Affiliate**, an applicant must:

- ☐ Complete and submit the application, with an original signature, date, and **fee**.
- ☐ **Education:**
  Provide your education history, which must include a minimum of a master's degree from a recognized institution of higher learning. Provide official transcripts with degree and date posted.
- ☐ **Supervision Contract:**
  Complete the **Supervision Contract** providing a formal written contract defining the parameters of the professional relationship.
- ☐ **Work History and Experience:**
  List your professional experience and work history from the date of completion from your education.
- ☐ **Examination:**
  Once all required documents have been received, you will be sent a Washington State law examination provided by the department.
- ☐ **Underlying License (RCW 18.155.020) :**
  A certified sex offender treatment provider means an individual who is a licensed marriage and family therapist, marriage and family therapist associate, mental health counselor, mental health counselor associate, psychiatrist, psychologist, social worker advanced, social worker associate advanced, social worker independent clinical, or social worker associate independent clinical as defined in **RCW 71.05.020**. All applicants are required to hold a license in Washington or a state or jurisdiction other than Washington. This underlying license must be maintained in good standing.
- ☐ Completion of the **signed statement form**. To be completed if your underlying license is in a state or jurisdiction other than Washington.
- ☐ Out-of-State credential Verification must be received from every state where you hold or have held a healthcare practitioner credential.

Washington State Department of HEALTH

Date Stamp Here

Revenue: 0252160000

Sex Offender Treatment Provider License Application

☐ Sex Offender Treatment Provider Certificate ☐ Sex Offender Treatment Provider Affiliate
☐ Sex Offender Treatment Provider Examination

Select if the following applies: ☐ Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	**National Provider Identifier Number (NPI)** (Enter 10 digit number)	☐ Male ☐ Female ☐ Prefer not to answer ☐ X

Name: First Middle Last

Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address

Mailing address if different from above address of record:

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ☐ ☐
   b. Diverted controlled substances or legend drugs? ☐ ☐
   c. Violated any drug law? ☐ ☐
   d. Prescribed controlled substances for yourself? ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ☐ ☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ☐ ☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ☐ ☐
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? ☐ ☐

3. Education

List in date order your educational preparation. Attach additional pages if you need more space.

Schools Attended Full Name, City and State	Degree Earned	Attendance Dates	
		Start (mm/yyyy)	End (mm/yyyy)

4. Experience

List in date order all your professional experience and practice from date of graduation from professional college. Include the month/day/year. Attach additional pages if you need more space.

Name of Business	Total Number of Months	Dates	
		Start (mm/yyyy)	End (mm/yyyy)

WAC 246-930-040 Professional Experience Requirement for Full Certification Applicants.

1. In order to qualify for examination, you need at least two thousand hours of treatment and evaluation experience, as defined in **WAC 246-930-010** and **WAC 246-930-350**. At least two hundred and fifty of these hours must be evaluation experience and at least two hundred fifty hours must be treatment experience.
2. All of the prerequisite experience must have been within the ten year period preceding application for certification as a provider.

   Do you have 250 hours of evaluation experience? ☐ Yes ☐ No

   Do you have 250 hours of treatment experience? ☐ Yes ☐ No

   Do you have a total of 2000 hours of experience? ☐ Yes ☐ No

5. Other License, Certification, or Registration

List all states, including Washington, where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. Attach additional pages if you need more space.

State Jurisdiction	License Number	License		Method of License
		Issue Date	Expiration Date	

6. Affiliate Applicants

Provide name, address and telephone number of your supervisor which you will be using when working with clients:

Provide a copy of the contract entered into by yourself and supervisor (**WAC 246-930-075(3)**).

Supervisor's Name _____

Work phone (enter 10 digit #) _____ Home phone (enter 10 digit #) _____

Supervisor's Address _____

City _____State _____ Zip Code _____

The provider shall ensure that the affiliate has completed at least one thousand hours of supervised evaluation and treatment experience before the affiliate is authorized to evaluate and treat Level III sex offenders.

The provider will submit to the department documentation that the affiliate has completed a minimum of one thousand hours within thirty days of completion of the experience.

7. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local, or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ By: _____
(mm/dd/yyyy) (Original signature of applicant)

Sex Offender Treatment Provider Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Request for Professional Training and References

Professional Training Obtained within the last three years (only applies to full certification applicants)

List 50 hours of training (courses, seminars, formal conferences, etc.) directly related to the treatment and evaluation of sex offenders or victims of abuse. Copies of program or course certificates are acceptable. Please review **WAC 246-930-070** for the training requirement.

Seminar Name	Date	Location	Sponsor	Hours

Source of Verification (only applies to full certification applicants)

List a professional reference(s) that can verify your experience requirement. Please review **WAC 246-930-040** for the certification experience requirement.

Name	Address	Telephone

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Sex Offender Treatment Provider Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Out-of-State Credential Verification

To Applicant:

Please complete this side of this form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered as a healthcare provider. The regulatory agency will complete page two.

Name: Last	First	Middle
Mailing Address		
City	State	Zip Code
Phone (enter 10 digit #)	Cell (enter 10 digit #)	
Email address		
Any other names used:		
Type of license(s) you hold or have held in other state(s):		
Washington State healthcare credential type you are applying for:		
Washington State healthcare credential number (if available):	Date Issued	

Have the licensing agency complete page two and return this form to the address listed above.

If you have any questions, please call 360-236-4700.

This form may be duplicated.

(To be Completed by the Regulatory Agency)

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

Name of license, certification, or registration holder:		
Authority providing verification: (state, name, and title)		
Applicant was credentialed by: ☐ Written Examination	Date:	Score:
Name of examination:		
☐ Other Examination	Date:	Score:
Name of examination:		
Is credential current: ☐ Yes ☐ No	Expiration Date:	
Is this individual considered to be in good standing in your state? ☐ Yes ☐ No If "no," please attach explanation.		
Has this credential ever been denied? ☐ Yes ☐ No Suspended? ☐ Yes ☐ No Revoked? ☐ Yes ☐ No Surrendered? ☐ Yes ☐ No Reinstated? ☐ Yes ☐ No If "yes," please provide a copy of the final order or other documentation of action taken.		
If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? ☐ Yes ☐ No		

(SEAL)

Signature: _____

Title: _____

Date: _____

Sex Offender Treatment Provider Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Signed Statement

(Per WAC 246-930-020)

I certify I submit to the jurisdiction of the Washington State courts for the purpose of any litigation involving my practice as a sex offender treatment provider, and service of process may be made in such cases pursuant to **RCW 4.28.180**; and

I do not intend to practice the health profession for which I am credentialed by another state within the state of Washington without first obtaining an appropriate credential to do so from the state of Washington, except as may be authorized by Washington State law.

Signature _____

Name _____
(Printed)

Dated this_____ day of _____year _____
day month year

Seal

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Sex Offender Treatment Provider Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Sex Offender Treatment Provider (SOTP) Supervision Contract

1. Affiliate Applicant

Name First	Middle	Last
Birth date (mm/dd/yyyy)	Underlying Credential Number	
Address		
City	State	Zip Code

2. Supervisor (Provider)

Supervisor Name	Phone (enter digit #)
SOTP Credential Number	Underlying Credential Number
Address	
City	State / Zip Code

WAC 246-930-075 Supervision of affiliates. Supervision of affiliates requires the provider take full ethical and legal responsibility for the quality of work of the affiliate. Supervision of affiliates shall involve regular, direct and face-to-face supervision.

This supervision contract must be submitted to the department for approval and shall include: Please attach documentation addressing these items.

- Supervised areas of professional activity.
- Amount of supervision time and the frequency of supervisory meetings. This information may be presented as a ratio of supervisory time to clinical work conducted by the affiliate.
- Supervisory fees and business arrangements.
- Nature of the supervisory relationship and the anticipated process of supervision.
- Selection and review of clinical cases.
- Methodology for record keeping, evaluation of the affiliate and feedback.
- How the affiliate will be represented to the public and the parties.

Provider:

- Avoid presenting as having qualifications in areas he or she does not have them.
- Provide sufficient training and supervision to the affiliate to assure the health and safety of the client and community.
- Have expertise and knowledge to directly supervise affiliate work.

- Assure the affiliate being supervised has sufficient and appropriate education, background and preparation for the work he or she will be doing. Cosign all written reports and correspondence prepared by the affiliate.
- Do not undertake a contract that exceeds the provider's ability to comply with the supervision standards.
- Assure the affiliate is prepared to conduct professional work. Assure adequate supervision of the affiliate. The provider shall meet face-to-face with the affiliate a minimum of one hour for every ten hours of supervised professional work. Supervision meetings occur at least every other week.
- Supervise no more than two affiliates.
- All work conducted by the affiliate is the responsibility of the provider. The provider shall have authority to direct the practice of the affiliate.
- It is the provider's responsibility to correct problems or end the supervision contract if the affiliate's work does not protect the interests of the clients and community. If the provider ends the contract, he or she must notify the department in writing within thirty days of ending the contract. A provider may only change or adjust a supervision contract after receiving written approval from the department.
- Supervision is a power relationship. The provider must not use his or her position to take advantage of the affiliate.
- The provider shall ensure the affiliate has completed at least one thousand hours of supervised evaluation and treatment experience before the affiliate is authorized to evaluate and treat Level III sex offenders. The provider will submit to the department documentation the affiliate has completed a minimum of one thousand hours within thirty days of completion of the experience.

Affiliate:

- Represent him or herself as an affiliate only when performing clinical work supervised by the contracted provider.
- Maintain full documentation of the work done and supervision provided.

I certify the information included in this contract is accurate, and I have read and understand the requirements in **WAC 246-930-075** Supervision of affiliates.

Supervisor name (print) _____

Supervisor signature _____ Date _____
mm/dd/yyyy

Affiliate applicant name (print) _____

Affiliate applicant signature _____ Date _____
mm/dd/yyyy

Please send the completed contract to the address above.

Sex Offender Treatment Provider Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Sex Offender Treatment Provider (SOTP) Supervised Experience Completion Verification

1. Applicant

Name First	Middle	Last
Birth date (mm/dd/yyyy)	Affiliate Number	
Address		
City	State	Zip Code

2. Supervisor (Provider)

Supervisor Name		Phone (enter digit #)
Credential Number	Type of Credential(s)	First Issue Date
Address		
City	State	Zip Code

3. Supervised Experience (WAC 246-930-075)

Applicants must have a minimum of 2000 hours; at least 250 hours of treatment experience and 250 hours of evaluation experience. These hours must be verified by the provider with whom the affiliate has a signed and approved contract on file with the Department of Health. Please complete the actual months under your supervision

Dates applicant was supervised: from _____ to _____

Please complete the actual hours under your supervision.

Supervision	Total Hours
Evaluation Experience (250 hours required).	
Estimate of evaluation hours counted other than face to face with a client.	
Treatment Experience (250 hours required).	
Estimate of treatment hours counted maintaining collateral contacts and written case/progress notes.	
Total number of supervised experience hours (2000 hours required).	

Supervisor

I certify the above information is, to the best of my knowledge, accurate and complete. I understand the department may request additional information, if it is needed, to evaluate the application of the individual named on this document. I also attest I have maintained an active SOTP and underlying credential during this time.

Signature _____ Date _____
mm/dd/yyyy

Return this form to the address listed above.

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Sex Offender Treatment Provider Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Sex Offender Treatment Provider (SOTP) Verification for Completion of 1000 hours of Supervised Experience

Use a separate form for each supervisor verifying your evaluation and treatment experience for each practice setting. This form may be duplicated. Fill out section 1 and forward the verification form to your supervisor(s) for completion.

1. Applicant

Name First	Middle	Last

Birth date (mm/dd/yyyy)	Affiliate Number

Street Address

City	State	Zip Code

2. Supervisor (Provider)

The above SOTP affiliate seeks verification of 1000 hours of evaluation and treatment experience. Please complete the following.

Supervisor Name	Phone Number

Credential Number	Type of Credential(s)	First Issue Date

Street Address

City	State	Zip Code

3. Supervised Experience (WAC 246-930-075)

Applicants must have completed at least 1000 hours of supervised evaluation and treatment experience before they are authorized to evaluate and treat Level III sex offenders. Please submit this form to the Department of Health within 30 days of completion of the 1000 hours. Please complete the actual months under your supervision.

Dates applicant was supervised: from _____ to _____
mm/dd/yyyy mm/dd/yyyy

Supervision	Total Hours
Number of Supervised experience hours (1000 hours required)	

Supervisor

I certify the above information is, to the best of my knowledge, accurate and complete. I understand the department may request additional information, if it is needed to evaluate the application of the individual named on this document. I also attest I have maintained an active SOTP and underlying credential during this time.

Signature _____ Date _____
mm/dd/yyyy

Return this form to the address listed above.

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RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Sex Offender Treatment Providers Laws, RCW 18.155

Sex Offender Treatment Providers Rules, WAC 246-930

Online

Sex Offender Treatment Provider, Web Page