



# HEALTH LICENSING OFFICE

## Sex Offender Treatment Board

1430 Tandem Ave. NE, Suite 180, Salem, OR, 97301

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[www.healthoregon.org/hlo](http://www.healthoregon.org/hlo) | Email: [hlo.info@state.or.us](mailto:hlo.info@state.or.us)

### **Associate Sex Offender Therapist 30 Hours Formal Training (Qualification through pathway one only)**

Please list a **minimum total of 30 hours of formal training specific to sex offender evaluation, assessment and direct treatment provision**. Please list the most recent experience first. Attach additional pages as needed. Refer to ORS 675.375(4) and OAR 331-810-0031(5).

**NOTE:** This training must have been obtained within three years prior to the date of application.

#### **NAME OF APPLICANT:**

#### **1. Training Information**

NAME OF TRAINER: LAST	FIRST	MI	TRAINER PHONE #:
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TRAINER ADDRESS:

CITY:	STATE:	ZIP:
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DATES OF TRAINING: FROM: TO:	Total number of formal training hours provided, specific to sex offender evaluation, assessment and direct treatment:
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Briefly describe the formal training provided specific to sex offender evaluation, assessment and direct treatment provisions **(attach additional pages if needed)**:

#### **Trainer Attestation**

**By signing below**, I attest that I provided the total number of sex offender evaluation, assessment and direct treatment formal training hours indicated above, to the above named applicant.

**Trainer's Signature:**

**Date:**

#### **2. Additional Training Information**

NAME OF ADDITIONAL TRAINER: LAST	FIRST	MI	TRAINER PHONE #:
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TRAINER ADDRESS:

CITY:	STATE:	ZIP:
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DATES OF TRAINING: FROM: TO:	Total number of formal training hours provided, specific to sex offender evaluation, assessment and direct treatment:
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Briefly describe the formal training provided specific to sex offender evaluation, assessment and direct treatment provisions **(attach additional pages if needed)**:

#### **Trainer Attestation**

**By signing below**, I attest that I provided the total number of sex offender evaluation, assessment and direct treatment formal training hours indicated above, to the above named applicant.

**Trainer's Signature:**

**Date:**