

Certified Associate Sex Offender Therapist Application Packet



**HEALTH LICENSING OFFICE
Sex Offender Treatment Board**

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

Phone: 503-378-8667 | Fax: 503-370-9004

www.healthoregon.org/hlo | Email: hlo.info@state.or.us

Return All Pages Of This Application And Keep A Copy For Your Records

Application

Certified Associate

Sex Offender Therapist

Please read all instructions thoroughly, and complete the application in full. An application that is deficient of any documentation will not be considered. If you need additional space to respond to a question, attach separate sheets, indexed to the appropriate question, to the back of the application.

To ensure appropriate review, all information should be typed or printed clearly. A resume cannot substitute for completion of the application. The application fee must accompany the documentation to determine eligibility for certification. The application fee is non-refundable.

For further information or additional assistance regarding the application or certification process, please contact the Health Licensing Office (HLO).

Phone: 503-378-8667

Fax: 503-370-9004

TTY: 503-373-2114

E-mail: hlo.info@state.or.us

Website: www.healthoregon.org/hlo

Mail original application, documentation and fees to:

**Health Licensing Office
Sex Offender Treatment Board
1430 Tandem Ave. NE, Suite 180
Salem, Oregon 97301**



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ASSOCIATE SEX OFFENDER THERAPIST CERTIFICATION APPLICATION

1. Applicant Information

APPLICANT NAME: LAST			FIRST			MIDDLE INITIAL		
RESIDENTIAL PHYSICAL ADDRESS (REQUIRED)								
CITY						STATE		ZIP
MAILING ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS)								
CITY						STATE		ZIP
PHONE: <input type="checkbox"/> HOME <input type="checkbox"/> CELL			BUSINESS TELEPHONE			EMAIL		
GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male			BIRTHDATE			SOCIAL SECURITY NUMBER (REQUIRED)		
<input checked="" type="radio"/> Have you ever been known under any other name? <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, list full name(s):								
<input checked="" type="radio"/> Do you hold or have you previously held licensure, certification or registration with the Health Licensing Office or any other state? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, please list information below.								
State:		Lic./Cert./Reg.#				Expiration:		
State:		Lic./Cert./Reg.#				Expiration:		
State:		Lic./Cert./Reg.#				Expiration:		

2. * (Complete This Section Only If Submitting Payment By Mail) *****

Method Of Payment For Application Fee = \$75	
Please check one: <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Money order <input type="checkbox"/> Purchase order <input type="checkbox"/> Credit card (see below)	
Type of Credit Card: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover (Cardholder must either be the applicant or be present at the time application is submitted) <u>Do Not Fax or Email Credit Card Information</u>	
Name on card: _____	
Card number: _____ Exp: _____ Authorized amount: \$ _____	
Cardholder signature: _____	
(Do not write in this section – Official use only)	
License #: _____ Initials _____ OTC <input type="checkbox"/> Verified ID <input type="checkbox"/> Type: _____	
<input type="checkbox"/> Approval Code/CK# _____	

3. Individual Records Questions: Please accurately answer all of the questions below. The Office may review your information through the Law Enforcement Data System, other governmental agencies, and private vendors to confirm the accuracy of the information. Any misrepresentation or failure to disclose information may result in disciplinary action.

● Are you now, or have you ever been, the subject of any active or inactive disciplinary action or voluntary resignation of a professional license, certificate, registration or permit imposed by a licensing or regulatory authority in this or any other state? Disciplinary action includes, but is not limited to, probation, suspension, civil penalty, or any other sanction limiting, in any way, a license, certificate, registration or permit. Yes No If yes, please explain (**attach additional pages if necessary**):

<p>● Have you ever been convicted of a misdemeanor or felony? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list all convictions, including the charges as stated in the court documents and year convicted (attach additional pages if necessary).</p>	<p>Year Convicted</p>

● As of today are you on probation or parole? Yes No If yes, you **must** provide a letter of release from your probation or parole officer authorizing you to obtain an authorization to practice. If you are on bench probation, or probation with the court, you must provide documentation of your conditions of the probation.

● Do you currently, or have you had within the past five (5) years, any physical, mental, or emotional condition which impaired, or does impair your ability to practice your profession safely and competently?
 Yes No If yes, please explain (**attach additional pages if necessary**):

● Do you currently have, or have you had within the past five (5) years, a dependency on the use of alcohol or drugs which impaired, or does impair, your ability to practice your health care profession safely and competently?
 Yes No If yes, please explain (**attach additional pages if necessary**):

● Are you currently participating in a diversion program for evaluation, treatment or monitoring for substance abuse or dependency, in lieu of or as a condition of resolving a matter before a healthcare program or facility, regulatory or licensing board, or criminal or civil court; or have you been notified that such action is pending or proposed?
 Yes No If yes, please explain(**attach additional pages if necessary**):

● Are you currently participating in a diversion program for evaluation, treatment or monitoring for correction of communication or sexual boundary issues, in lieu of or as a condition of resolving a matter before a healthcare program or facility, regulatory or licensing board, or criminal or civil court; or have you been notified that such action is pending or proposed? Yes No If yes, please explain (**attach additional pages if necessary**):

4. Applicant Attestation

I, _____, certify that I am the person described and identified in this application.
NAME OF APPLICANT

I have read ORS 675.375(4) and OAR 331-810-0031; I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Health Licensing Office (HLO) may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases. I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the HLO any information, files or records required by that office in connection with processing this application. I further affirm that I will keep HLO informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public. Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Oregon.

Applicant Signature:

Date:

As part of your application for initial or renewed occupational or professional license, certification, or registration issued by the Health Licensing Office, you are required to provide your Social Security number (SSN) to the Office. This is mandatory. The authority for this requirement is ORS 25.785, ORS 305.385, 42 USC §405(c)(2)(C)(i), 42 USC § 666(a)(13), and 41 CFR 61.7. Failure to provide your SSN will be a basis to refuse to issue or renew the license, certification, or registration you seek. This record of your SSN is used for child support enforcement and tax administration purposes (including identification). The HLO will use your SSN for these purposes only, unless you authorize other uses of the number. Your SSN will remain on file with the Office.

I have examined this application and certify that it is true, correct, and complete. I understand that knowingly making a false statement on this application will be cause for denial, suspension, or revocation of my license, certification or registration. I have enclosed the required fees and documentation.

Applicant Signature:

Date:

ORS 181.534, 670.280, 676.608, and 676.612 authorize the Health Licensing Office to conduct criminal background checks and the office requests that you voluntarily provide your Social Security number for this purpose. I understand my application may be subject to a criminal background check.

Before issuing a default final order, the Health Licensing Office must determine the military status of a Respondent, under 50 USC App § 521(b) (Supp. 2005). Your Social Security Number may be used in order to verify your military status (or lack thereof).

If any disciplinary action is taken against your license, certification, or registration, your Social Security Number may be reported to the federal Health Care Integrity and Protection Data Bank (NPDB) under Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986 (Title IV); Section 1921 of the Social Security Act (Section 1921); Section 1128E of the Social Security Act (Section 1128E); and their implementing regulations found at 45 CFR Part 60.

I hereby voluntarily consent to disclose my Social Security number to the HLO for criminal background checks, verification of military status, and reports to the Health Care Integrity and Protection Data Bank. Failure to provide your Social Security number for these purposes will not be used as a basis to deny your application, or to deny you any right, benefit or privilege provided by law. If you consent to the use of your Social Security number by the HLO for these purposes, it may be used only for these purposes.

Applicant Signature:

Date:

5. Affirmative Action – Voluntary Question

The State of Oregon has an Affirmative Action Policy. If you choose to provide this information, it will help us evaluate the effectiveness of our affirmative action programs. This information will also be used in the aggregate (i.e. as a whole, not individually) for research and statistical purposes. It will not be tied specifically or directly to your licensing information.

Ethnic Background *(check only one)*

- (A) **Asian or Pacific Islander:** Persons having origins in any of the peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.
- (B) **African American *(not of Hispanic origin)*:** Persons having origins in any of the Black racial groups of Africa.
- (H) **Hispanic:** Persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish cultures or origin, regardless of race.
- (I) **American Indian or Alaskan Native:** Persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.
- (W) **Caucasian *(not of Hispanic origin)*:** Persons having origins in any of the original peoples of Europe, North Africa or the Middle East.

REQUIREMENTS FOR ASSOCIATE SEX OFFENDER THERAPIST CERTIFICATION

To be issued a certification for Associate Sex Offender Therapist an applicant must:

- Meet the requirements of OAR 331 Division 30;
- Submit a completed application form prescribed by the Office, which must contain the information listed in OAR 331-030-0000 and be accompanied by payment of the required application fees = **\$75** (*see method of payment section above*);
- Submit one form of acceptable **photographic** identification as outlined in OAR 331-030-0000(10), **which must include applicant's current legal name:** Front and back of legible (clear) photocopies if submitted by mail; *driver license, state ID card, passport or military ID card*;
- Submit a Professional Disclosure Statement, pursuant to ORS 675.375 or ORS 675.380, that must include the following as defined in ORS 675.365(5);
 - (a) Name, business address and telephone number;
 - (b) Philosophy and approach to treatment and rehabilitation of sex offenders;
 - (c) Formal education and training;
 - (d) Continuing education experience and name of supervisor, if any;
 - (e) Fee schedules for sex offender treatment services; and
 - (f) The name, address and telephone number of the Sex Offender Treatment Board;
- Submit to a fingerprint-based national criminal background check pursuant to OAR 331-030-0004;
- Provide documentation of completing a qualifying pathway (**See qualifying pathways below**); and
- Upon determination of qualification for licensure by the Office, submit required license fee.

PATHWAY ONE: QUALIFICATION THROUGH EDUCATION, TRAINING AND EXPERIENCE

Applicant must:

- Submit official transcripts from a college, university and post graduate records, showing attainment of at least a bachelor's degree in the Board-approved behavioral sciences. For a list of Board-approved degrees, go to www.healthoregon.org/hlo and select "Sex Offender Treatment Board";
- Submit proof of having at least 1,000 hours of direct clinical contact with sex offenders, as defined in OAR 331-800-0010(3), submitted on a Direct Clinical Contact Experience form;
- Be under the direct supervision of a certified clinical sex offender therapist;
- Submit proof of having at least 30 hours of formal training specific to sex offender evaluation, assessment and direct treatment provision. The training must have been obtained in the three years prior to the application date, and submitted on a Formal Training Qualification form; and
- Submit verification of and compliance with the requirements of direct supervision by a certified clinical sex offender therapist, in accordance with OAR 331-810-0055 and 331-810-0060.

PATHWAY TWO: QUALIFICATION THROUGH RECIPROCITY

Applicant must:

- Submit an affidavit of licensure, pursuant to 331-030-0040, demonstrating proof of holding a current certification as a clinical sex offender therapist or associate sex offender therapist in another state, and has no current or pending disciplinary action against the certification. The certification requirements must be substantially equivalent to Oregon certification requirements pursuant to ORS 675.380 and the Affidavit of Licensure – Licensing Credential, must be mailed directly to the Health Licensing Office from the appropriate sex offender therapist licensing or certifying agency; and
- Provide any other information as may be requested by the HLO to determine equivalent education, experience and formal training for Oregon certification as an associate sex offender therapist.

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Associate Sex Offender Therapist Direct Clinical Contact Experience (Qualification through pathway one only)

Please list a **minimum total of 1,000 hours of professional experience in direct clinical contact with sex offenders** as defined in OAR 331-800-0010(3), listing the most recent experience first. Attach additional pages as needed. Refer to ORS 675.375(4) and OAR 331-810-0031(3).

“Direct clinical contact” means services provided with the primary purpose of assessment and developing and implementing a treatment plan focused on sex-offense-related behavior.

1. Experience History

PRESENT OR MOST RECENT EMPLOYER:		EMPLOYER ADDRESS:		
CITY:			STATE:	ZIP:
DATES OF EMPLOYMENT: FROM: TO:		TOTAL NUMBER OF HOURS WORKED WEEKLY:	AVERAGE NUMBER OF “DIRECT CLINICAL CONTACT” HOURS PER WEEK:	TOTAL NUMBER OF “DIRECT CLINICAL CONTACT” HOURS WORKED:
APPLICANT JOB TITLE:		NAME OF SUPERVISOR:		EMPLOYER PHONE #:

Briefly describe duties as related to sex offender assessment, development and implementation of treatment plan (**attach additional pages if necessary**):

Describe client population:

ADDITIONAL EMPLOYER:		EMPLOYER ADDRESS:		
CITY:			STATE:	ZIP:
DATES OF EMPLOYMENT: FROM: TO:		TOTAL NUMBER OF HOURS WORKED WEEKLY:	AVERAGE NUMBER OF “DIRECT CLINICAL CONTACT” HOURS PER WEEK:	TOTAL NUMBER OF “DIRECT CLINICAL CONTACT” HOURS WORKED:
APPLICANT JOB TITLE:		NAME OF SUPERVISOR:		EMPLOYER PHONE #:

Briefly describe duties as related to sex offender assessment, development and implementation of treatment plan (**attach additional pages if necessary**):

Describe client population:

2. Attestation

By signing below, I attest that I have provided a true and accurate accounting of my Direct Clinical Contact experience with sex offenders as indicated above.

Applicant Signature:

Date:

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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 necessary)**:

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 necessary)**:

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:

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Associate and Clinical Sex Offender Therapist Supervision Requirements

ORS 675.375(4) To qualify as a certified associate sex offender therapist, the applicant must:

(e) Be under the direct supervision of a certified clinical sex offender therapist.

ORS 675.365(4) "Direct supervision" means a minimum of two hours of supervision by a certified clinical sex offender therapist for each 45 hours of direct clinical contact with a sex offender.

NOTE: The Sex Offender Treatment Board (SOTB) recommends one hour of supervision for each 10 hours of direct clinical contact with a sex offender.

331-810-0055

Supervision – clinical sex offender therapists

A certified clinical sex offender therapist who is supervising a certified associate sex offender therapist must:

- (1) Enter into a formal contract prescribed by the Office with a certified associate sex offender therapist that specifies:
 - (a) The duties of a certified associate sex offender therapist;
 - (b) The scope and focus of the supervision; and
 - (c) Frequency and durations of meetings between the supervisor and the certified associate sex offender therapist to review the certified associate sex offender therapist's professional performance.
- (2) Document dates and content of supervision meetings and make the information available to the Office if requested.
- (3) Provide ongoing oversight to the certified associate sex offender therapist as defined in 331-800-0010 (7).
- (4) Sign reports and correspondence prepared by the certified associate sex offender therapist.
- (5) Supervise no more than four full-time or the equivalent certified associate sex offender therapists.
- (6) Ensure that the certified associate sex offender therapist has sufficient training, education, background, preparation and supervision in order to evaluate and treat sex offenders.
- (7) Notify the Office in writing within 10 business days of ending the supervision contract.
- (8) Maintain supervision records for a minimum of 5 years after the last day of supervision. Upon request, you must make the records available to the Office.

331-810-0060

Supervision – associate sex offender therapists

A certified associate sex offender therapist must:

- (1) Enter into a formal contract prescribed by the Office with a certified clinical sex offender therapist that specifies:
 - (a) The duties of a certified associate sex offender therapist;
 - (b) The scope and focus of the supervision; and
 - (c) Frequency and durations of meetings between the supervisor and the certified associate sex offender therapist to review the certified associate sex offender therapist's professional performance.
- (2) Notify the Office in writing within 10 business days of ending the supervision contract.
- (3) Identify themselves as a certified associate sex offender therapist on all materials relating to the provision of sex offender treatment or the offering or advertising of sex offender treatment. This disclosure includes, but is not limited to: letterhead, business cards, telephone directory listings, internet postings, brochures, insurance billing and any other public or private materials. These representations must include the individual's title as a "certified associate sex offender therapist" and the supervisor's name and designation "supervisor."
- (4) Document dates and content of supervision meetings. Upon request, you must make the records available to the Office.

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***Certified Associate Sex Offender Therapist
Supervision Contract (Page 1 of 2)***

1. Applicant Information

APPLICANT NAME: LAST	FIRST	MIDDLE INITIAL	DATE
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2. Supervisor Information

NAME: LAST	FIRST	MIDDLE INITIAL
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DEGREE(S)	LICENSE #
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EMPLOYER

PHYSICAL ADDRESS

CITY	STATE	ZIP
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DATES OF PROPOSED SUPERVISION:	Planned frequency and duration of meetings to review the supervisee's performance:		
FROM:	TO:	HOW OFTEN:	HOW LONG: HRS MIN

Please describe the duties of the supervisee (***attach additional pages if necessary***);

Please describe the scope and focus of the supervision (***attach additional pages if necessary***);

WHERE WILL SUPERVISION TAKE PLACE? SUPERVISOR'S OFFICE SUPERVISEE'S OFFICE

NAME OF FACILITY WHERE SUPERVISION WILL TAKE PLACE:

ADDRESS OF FACILITY (*PHYSICAL LOCATION*):

CITY:	STATE:	ZIP:
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***Certified Associate Sex Offender Therapist
Supervision Contract (Page 2 of 2)***

3. Responsibilities

This form identifies the responsibilities of the Associate Sex Offender Therapist and supervising Certified Clinical Sex Offender Therapist. Please read this form; both the applicant and supervisor must sign this document.

Applicant:

By signing below I agree to the following:

I will notify the Office in writing within 10 business days of ending the supervision contract.

I will identify myself as a certified associate sex offender therapist on all materials relating to the provision of sex offender treatment or the offering or advertising of sex offender treatment. This disclosure includes, but is not limited to: letterhead, business cards, telephone directory listings, internet postings, brochures, insurance billing and any other public or private materials. These representations will include my title as a "certified associate sex offender therapist" and the supervisor's name and designation "supervisor."

I will document dates and content of supervision meetings, and upon request I will make the records available to the Office.

Supervising Certified Clinical Sex Offender Therapist:

By signing below I agree to the following:

I will document dates and content of supervision meetings and make the information available to the Office if requested.

I will provide ongoing oversight to the certified associate sex offender therapist as defined in 331-800-0010 (7).

I will sign reports and correspondence prepared by the certified associate sex offender therapist.

I will supervise no more than four full-time or the equivalent certified associate sex offender therapists.

I will ensure that the certified associate sex offender therapist has sufficient training, education, background, preparation and supervision in order to evaluate and treat sex offenders.

I will notify the Office in writing within 10 business days of ending the supervision contract.

I will maintain supervision records for a minimum of 5 years after the last day of supervision. Upon request, you must make the records available to the Office.

All contracts require signatures of the applicant and supervisor. Both signatures must be completed before submitting your application. Unsigned forms will be returned, delaying the approval process.

Certification:

I certify that the information provided in this document is true and correct to the best of my knowledge. I agree to work under this supervision contract as described above.

Signatures:

Applicant: _____ Date: _____

Supervising Certified Clinical
Sex Offender Therapist: _____ Date: _____



State of Oregon
HEALTH LICENSING OFFICE
OREGON HEALTH AUTHORITY

Signed Statement
ORS 675.375(4)

I certify that I submit to the jurisdiction of the Oregon state courts for the purpose of any litigation involving my practice as a sex offender treatment supervisor, and that service of process may be made in such cases pursuant to ORS 675.375(4); and

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

SIGNATURE

NAME (Typed or printed)

DATED THIS _____ DAY OF _____
Day Month Year