

Certified Clinical Sex Offender Therapist Application Packet



Oregon
Health
Authority

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

Application

Certified Clinical

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 this office.

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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CLINICAL 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: Cash Check Money order Purchase order Credit card (see below)

Type of Credit Card: Visa MasterCard Discover (Cardholder must either be the applicant or be present at the time application is submitted) **Do Not Fax or Email Credit Card Information**

Name on card: _____

Card number: _____ Exp: _____ Authorized amount: \$ _____

Cardholder signature: _____

(Do not write in this section – Official use only)

License #: _____ Initials _____ OTC Verified ID Type: _____

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>	Year Convicted

● 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(3) and OAR 331-810-0020; 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 HLO any information, files or records required by HLO 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 CLINICAL SEX OFFENDER THERAPIST CERTIFICATION

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

- Meet the requirements of OAR 331 Division 30;
- Submit a completed application form prescribed by the HLO, 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 agency, submit required license fee.

PATHWAY ONE: QUALIFICATION THROUGH OREGON MENTAL HEALTH PROFESSIONAL LICENSURE, EDUCATION, TRAINING AND EXPERIENCE

Applicant must:

- Hold a valid Oregon Mental Health Professional license as provided in OAR 331-810-0020(3);
- Submit proof of holding a valid Oregon Mental Health Professional license by means of an Affidavit of Licensure – Licensing Credential, mailed directly to the Health Licensing Office from the appropriate Oregon mental health licensing or certifying agency;
- Submit proof of holding at least a master's degree in a Board-approved the behavioral science field. For a current list of Board-approved degrees, go to www.healthoregon.org/hlo and select Sex Offender Treatment Board;
- Submit proof of having at least 2,000 hours of direct clinical contact with sex offenders not less than three years and not more than six years prior to application, which must include:
 - a)** 1,000 hours of direct treatment services as defined in 331-800-0010(5), submitted on a Direct Services Treatment form;
 - b)** 500 hours of evaluation experience, submitted on a Professional Evaluation Activities form; and
 - c)** 500 hours of treatment-plan related activity, submitted on a Treatment-plan Related Activities form, including documented activities as outlined in OAR 331-810-0020(4)(c); and
- Submit proof of having at least 60 hours of formal training specific to sex offender evaluation, assessment and direct treatment provision, obtained within the three years prior to application, submitted on a Formal Training Qualification form.

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 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 a clinical sex offender therapist.

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Direct Clinical Contact Experience

Sex Offender Direct Clinical Contact – 2,000 Hours

ORS 675.375 Certification of clinical sex offender therapist or associate sex offender therapist; requirements

- (3) To qualify as a certified clinical sex offender therapist, the applicant must:
- (a) Be in compliance with applicable provisions and rules adopted by the HLO;
 - (b) Have at least a master's degree in the behavioral sciences;
 - (c) Have an active Oregon mental health professional license or equivalent license as determined by the Office;
 - (d) Within not less than three years nor more than six years prior to application, have had a minimum of 2,000 hours of direct clinical contact with sex offenders, including:**
 - (A) 1,000 hours of direct treatment services; and
 - (B) 500 hours of evaluations; and
 - (e) Have a minimum of 60 hours of formal training applicable to sex offender treatment and evaluation, achieved within the three years prior to application.

OAR 331-810-0020

- (4) Submit proof of having at least 2,000 hours of direct clinical contact with sex offenders not less than three years and not more than six years ago. The hours include:
- a) 1,000 hours of direct treatment services; and**
 - b) 500 hours of evaluations; and**
 - c) 500 hours of treatment-plan related activity, including report writing, clinical consultations, case management, charting, peer review and consultations, meeting with attorneys, parole officers, families, victims and other members of the sex offender's social network.**

OAR 331-800-0010

- (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.
- (5) **“Direct treatment services”** means individual, group or family therapy that focuses on the sex offense-related behavior; the sex offender must be present.
- (9) **“Treatment plan”** means a written statement of intended care and services as documented in the evaluation that details how the sex offender's treatment needs will be met while protecting the community during the treatment.

NOTE: Please complete *Direct Clinical Contact Experience form (attached)*. Use additional pages as needed to document required experience.



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

Please attest to a **minimum total of 2,000 hours of Direct Clinical Contact** with sex offenders as indicated below:

OAR 331-810-0020(4)

- (a) 1,000 hours of professional experience in Sex Offender Direct Treatment Services** as defined in OAR 331-800-0010(5). "Direct treatment services" means individual, group or family therapy that focuses on the sex offense-related behavior; the sex offender must be present;
- (b) 500 hours of professional experience in Sex Offender Evaluations;**
- (c) 500 hours of professional experience in Treatment-plan Related Activities.** "Treatment-plan related activity includes, report writing, clinical consultations, case management, charting, peer review and consultations, meeting with attorneys, parole officers, families, victims and other members of the sex offender's social network."

NOTE: Experience must have been obtained not less than three years and not more than six years ago. Please list the most recent experience first. Attach additional pages as needed.

1. Experience History

PRESENT OR MOST RECENT EMPLOYER:		EMPLOYER ADDRESS:		
CITY:		STATE:	ZIP:	
DATES OF EMPLOYMENT: FROM: TO:		Total number of "Direct Treatment Services" hours worked:	Total number of "Evaluation" hours worked:	Total number of "Treatment-plan Related Activity" hours worked:
JOB TITLE:		NAME OF SUPERVISOR:		EMPLOYER PHONE #:
ADDITIONAL EMPLOYER:		EMPLOYER ADDRESS:		
CITY:		STATE:	ZIP:	
DATES OF EMPLOYMENT: FROM: TO:		Total number of "Direct Treatment Services" hours worked:	Total number of "Evaluation" hours worked:	Total number of "Treatment-plan Related Activity" hours worked:
JOB TITLE:		NAME OF SUPERVISOR:		EMPLOYER PHONE #:
ADDITIONAL EMPLOYER:		EMPLOYER ADDRESS:		
CITY:		STATE:	ZIP:	
DATES OF EMPLOYMENT: FROM: TO:		Total number of "Direct Treatment Services" hours worked:	Total number of "Evaluation" hours worked:	Total number of "Treatment-plan Related Activity" hours worked:
JOB TITLE:		NAME OF SUPERVISOR:		EMPLOYER PHONE #:

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:

Formal Training

Formal Training Specific to Sex Offender Evaluation, Assessment and Direct Treatment Provision - 60 Hours

ORS 675.375 Certification of clinical sex offender therapist or associate sex offender therapist; requirements;

- (3) To qualify as a certified clinical sex offender therapist, the applicant must:
- (a) Be in compliance with applicable provisions and rules adopted by the HLO;
 - (b) Have at least a master's degree in the behavioral sciences;
 - (c) Have an active Oregon Mental Health Professional license or equivalent license as determined by the HLO;
 - (d) Within not less than three years nor more than six years prior to application, have had a minimum of 2,000 hours of direct clinical contact with sex offenders, including:
 - (A) 1,000 hours of direct treatment services; and
 - (B) 500 hours of evaluations; and
 - (e) Have a minimum of 60 hours of formal training applicable to sex offender treatment and evaluation, achieved within the three years prior to application.**

OAR 331-810-0020

- (5) Submit proof of having at least 60 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.

Note: Please complete *Clinical Sex Offender Therapist Formal Training form (attached)*. Use additional pages as needed to document required training.



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Clinical Sex Offender Therapist 60 Hours Formal Training (Qualification through pathway one only)

Please list a **minimum total of 60 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(3)(e) and OAR 331-810-0020(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:		
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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:		
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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:



State of Oregon
HEALTH LICENSING OFFICE
OREGON HEALTH AUTHORITY

Signed Statement
ORS 675.375(3)

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 provider, and that service of process may be made in such cases pursuant to ORS 675.375(3); 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

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