APPLICATION FOR ENTRY LEVEL PLACEMENT ON THE APPROVED PROVIDER LIST

COLORADO DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD

COLORADO DEPARTMENT OF PUBLIC SAFETY
DIVISION OF CRIMINAL JUSTICE

700 Kipling Street, Suite 1000
Denver, CO 80215
Tel: (303) 239-4528 or 1-800-201-1325 (in Colorado only)
Fax: (303) 239-4491
http://dcj.state.co.us/odvsom

October 2011

TABLE OF CONTENTS

Instructions 3
Frequently Asked Questions........ 4

SECTION I

Specific Entry Level Provider Forms 5
- General Introductory Information for Entry Level Applicants 5
- Instructions for DV Clinical Supervisors 5
- A. Verification of Trainings 6
- B. Verification of Experiential Hours 10
- C. Verification of Ongoing Clinical Supervision 11
- D. Verification of Ongoing Co-Facilitation 12
- E. DV Offender Treatment Philosophy Statement 13
- F. Offender Evaluations 13
- G. Letter from Victim Advocate 13

SECTION II

General Required Forms 14
- A. DORA Verification 15
- B. Contact Information for Your References 16
- C. Certification and Licensure........ 17
- D. Background and Identifying Information 18
- E. Statement of Understanding 19
- F. Criminal Background Information 20
- G. Statements of Compliance 21
- H. Education 22
- I. Fingerprint Card Instructions 23

Application and Information For Entry Level Provider

Who should fill out this application?

This application is for individuals wishing to be placed at **Entry Level** on the Approved Provider List of Domestic Violence Offender Treatment Providers (hereafter called the Approved Provider List). Applicants must demonstrate that they meet the qualifications of, and will comply with, standards of practice contained in the *Standards for Treatment with Court Ordered Domestic Violence Offenders* published by the Domestic Violence Offender Management Board (hereafter referred to as the *Standards*). **It is the applicant's responsibility to ensure he/she obtains the most current version of the *Standards***. Applicants apply as individuals, not partnerships or programs.

This application is for applicants applying to work with male domestic violence offenders.

If an applicant is seeking to work with female or same-sex domestic violence offenders, please refer to *Standard 10.0,* complete the Special Offender Population application and submit it with this application.

INSTRUCTIONS

1. Use ONLY the forms provided.
2. Submit ONLY the information requested.
3. Submit the required information in the order requested.
4. Follow all instructions carefully – incomplete or incorrect applications may be returned.
5. The Application Review Committee (Committee) meets monthly. New applications are normally reviewed within one to two months of receipt. The Committee will then notify the applicant of any missing documentation. Applications must be completed within eight months from date of submission. (Please refer to administrative policy on time limits in Appendix D of the *Standards*.)
6. PLEASE DO NOT use staples, paper clips, binders, sheet protectors, or other materials.

   FEES: THE FEE FOR ENTRY LEVEL APPLICATION IS $200. PLEASE SEE BELOW FOR INSTRUCTIONS ON PAYMENT.

7. A money order for $39.50 made payable to CBI must be included for the processing of your fingerprint card.
8. A money order for $160.50 made payable to Colorado Department of Public Safety.
9. If you download your application from the Domestic Violence website, *please note that you still need to request a fingerprint card from the Domestic Violence Offender Management Board to complete your application*. Please call (303) 239-4528 to request a fingerprint card. You **MUST** use our official fingerprint card.

THE STANDARDS WILL SUPERCEDE IN THE EVENT OF ANY ERRORS IN THIS APPLICATION.

Frequently Asked Questions

How can an applicant prepare for completing this application?

- **An applicant should first read and understand the *Standards* before completing this packet.** Applicant may follow along using the *Standards* to clarify application requirements. Applicants will also need to meet with their DV Clinical Supervisor in completing the application.

What should an applicant do upon completion of this application?

- When completed, send application in hard copy to: Domestic Violence Offender Management Board/Division of Criminal Justice, 700 Kipling Street, Suite 1000, Denver, CO 80215. (Please keep a copy of your completed application for your records.)

How long will the entire application review process take?

- The Committee will usually review your application within one to two months of receipt. You can expedite the process by submitting all of your application materials at one time and in the required order. (Note: If your packet is incorrect or incomplete, this slows down the approval process).

Where can additional copies of the Standards and application forms be found?

- Additional copies of the *Standards* and application materials may be obtained by calling (303) 239-4528. They are also available at: http://dcj.state.co.us/odvsom

What if an applicant has questions or needs more information?

- For questions, contact the Domestic Violence Offender Management staff at (303)-239-4528.

How will compliance with the Standards be assured?

- Compliance with the *Standards* will be assessed through reapplication and possible audits. Mechanisms are in place to receive and investigate complaints through the Department of Regulatory Agencies.

PLEASE REMOVE PAGES 1 - 5 BEFORE RETURNING THIS APPLICATION.

SECTION I

SPECIFIC ENTRY LEVEL FORMS

General Introductory Information for Entry Level Applicants
Applicants are those who have never been on the DVOMB Approved Provider List. All Entry Level applicants shall meet the following educational, experiential, and supervision or peer consultation criteria for approval.

All applicants involved in domestic violence offender treatment must have an Approved Provider as a co-facilitator until approval from the Board is granted. New applicants who are co-facilitating any domestic violence offender treatment must have supervision in accordance with the *Standards*.

Reference *Standards*, Section 9.0

Entry Level Applicant Supervision:
Applicants are required to have DV clinical supervision for a minimum of 1 hour per month for up to 10 client contact hours, and 2 hours per month for 10 or more client contact hours or additional supervision as determined by the DV Clinical Supervisor. Applicants who are not providing direct services to offenders may request an exception to the supervision requirement.

Reference *Standards*, Section 9.0

Instructions for DV Clinical Supervisors
As a DV Clinical Supervisor, the DVOMB values your expertise, perspectives and feedback regarding this applicant. Therefore, applicants are required to have a DV Clinical Supervisor involved in his/her training, experience, and application to the DVOMB for placement on the Approved Provider List. Applicants are required to receive supervision, guidance and evaluation from their DV Clinical Supervisor. Collaboration with probation officers and victim advocates should also be included in the applicant's training and experience. Below are the required minimum components for DV Clinical Supervisor involvement in the application process.

Please notify the DVOMB in writing if you discontinue your DV clinical supervision for this applicant, including once he/she becomes an Approved Provider.

Note: DV Clinical Supervisors may require applicants to obtain verification from other supervisors for their previously completed trainings or experiential hours.

- **A. Verification of Trainings**
- **B. Verification of Experiential Hours**
- **C. Verification of Ongoing Supervision**
- **D. Verification of Co-facilitation**
- **E. Review all clinical documentation submitted by applicant**
  1. **Domestic Violence Offender Treatment Philosophy Statement**
  2. **Offender Evaluations**

SECTION I

A. Verification of Trainings

Reference the Standards Section 9.01 (J)

Directions for Applicant

Masters degree applicants:

77 hours of documented training specifically related to domestic violence evaluation and treatment methods are required.

Bachelor's degree applicants:

112 hours of documented training specifically related to domestic violence evaluation and treatment methods are required.

Please list the trainings you attended using the title printed on the certificate and indicate the date and the number of hours. You must complete the required trainings listed below. Training must be obtained from a minimum of 3 different trainers and/or training agencies in order to be exposed to diverse philosophies, styles and theories. *You must submit a* ***copy*** *of your certificate of attendance for each training you attended. (Training certificates will be randomly audited.)*

Required Trainings

(All 15 hours are allocated to the *Evaluation & Assessment* and the *Facilitation & Treatment* categories below)

	Training Date	Hours
☐ 7 Hour DVOMB Current Standards Training	______________	**7**
☐ DVRNA Training (from DVOMB only)	______________	**4**
☐ SARA Training from approved SARA Trainer	______________	**4**

REQUIRED TRAININGS TOTAL: 15

Basic Counseling Skills: Bachelor degree applicants (35 hours required)

Applicants with a masters degree in a counseling related field, or Certified Addictions Counselor II, or higher do **not** need to document these training hours. Topics: c*ounseling techniques, individual and group skills, treatment planning, group dynamics.*

	Training Date	Hours
Title: ______________________________	______________	_______
Title: ______________________________	______________	_______
Title: ______________________________	______________	_______
Title: ______________________________	______________	_______

BASIC COUNSELING TOTAL: 35

A. Verification of Trainings (cont.)

Domestic Violence Victim Issues (21 hours)
These hours must focus on DV victim issues.
Topics: *Role of victim advocate in domestic violence offender treatment, offender containment and working with a victim advocate, crisis intervention, legal issues including confidentiality, duty to warn, and orders of protection, impact of domestic violence on victims, safety planning , victim dynamics to include obstacles and barriers to leaving abusive relationships, trauma issues.*

	Training Date	Hours
Title: ______________________	____________	______
Title: ______________________	____________	______
Title: ______________________	____________	______
Title: ______________________	____________	______
Title: ______________________	____________	______

DOMESTIC VIOLENCE VICTIM ISSUES TOTAL: 21

Domestic Violence Offender Evaluation and Assessment (28 hours)
These hours must focus on DV offender evaluation and assessment issues.
12 hours of this category are fulfilled under the **Required Training** category above. The balance of the required hours (i.e. **16 hours) must** be obtained from the following topic areas.

Topics: *DV clinical interviewing skills, substance abuse screening, use of collateral sources of information, types of abuse, DV offender typologies, cognitive distortions.*

	Training Date	Hours
Title: ______________________	____________	______
Title: ______________________	____________	______
Title: ______________________	____________	______
Title: ______________________	____________	______
Title: ______________________	____________	______

DOMESTIC VIOLENCE OFFENDER EVALUATION & ASSESSMENT TOTAL: 16

SECTION I

A. Verification of Trainings (cont.)

Facilitation and Treatment Planning (28 hours)
3 hours of this category are fulfilled under the **Required Training** category above. The balance of the required hours (i.e. **25 hours) must** be obtained from the following topic areas.
Topics: *Criminal-thinking errors, criminogenic needs, offender self management, motivational interviewing, provider role in offender containment, forensic psychotherapy, coordination with criminal justice system, offender accountability, recognizing and overcoming offender resistance, offender contracts, ongoing assessment: skills and tools, offender responsivity to treatment, levels & competencies.*

	Training Date	**Hours**
Title: ______	______	______
Title: ______	______	______
Title: ______	______	______
Title: ______	______	______
Title: ______	______	______

FACILITATION AND TREATMENT PLANNING TOTAL: 25

* *

TOTAL TRAINING HOURS SHOULD EQUAL**:**

☐ **77** for Master's Degree applicants, *or*

☐ **112** for Bachelor's Degree applicants

TOTAL TRAINING HOURS: ______

____
(Applicant Signature) (Date)

SECTION I

A. Verification of Trainings (cont.)

☐ **Please have your DV clinical supervisor review your trainings & certificates and verify by completing this form.**

I, ____ , do hereby verify that I have reviewed
(DV Clinical Supervisor)

____ 's training certificates and, therefore,
(Applicant)
verify that the applicant has received (please circle one) 77 hours for master's degree *or* 112 hours for bachelor's degree of documented training specifically related to domestic violence evaluation and treatment methods.

____
(DV Clinical Supervisor's signature) (Date)

☐ **Optional**: **Alternative supervisor verification of training**

I verify that ____ has received __________ hours of
(Applicant)

training specifically related to domestic violence evaluation and treatment methods.

Alternate supervisor's name: ________________________________Agency: _________________________
(please print)

Alternate supervisor's signature _____________________________________ Date ____________________

SECTION I

B. Verification of Experiential Hours

Reference the Standards Section 9.01, (II)

Directions for Applicant:

Please have your domestic violence clinical supervisor verify these hours and complete this form. Supervisors may require applicant to provide verification and/or obtain additional supervisors' signatures.

Please provide name of agency where experience was gained.

I, ____ do hereby verify that I have reviewed documentation
(DV Clinical Supervisor)

and that ____, has completed **all** of the following experiential hours
(Applicant)

and received the required clinical supervision per the *Standards*, *Section 9.01*.

____ ________________________
(DV Clinical Supervisor's signature) Date

300 Hours General Experiential Counseling. These hours shall be face-to-face client contact hours providing evaluations and/or individual and/or group counseling sessions. *Standard* Section 9.01 (II) (A). (If the applicant has a master's degree in counseling or a CAC II or higher, a copy of the certification or transcript verifying an internship will satisfy this requirement.) The Applicant must have received 15 hours of clinical supervision for the 300 hours of general experiential counseling hours.

____
(*Name of agency where experience was gained*)

Or (**Optional**): I verify that the applicant has completed this requirement at
Agency____ Dates: _________________________________

Alternate supervisor's signature _____________________________________ Date _______________________

108 Hours (master's degree applicants) or
216 hours (bachelor's degree applicant) of face-to-face client contact hours working with domestic violence offenders directly observed by a Full Operating Level Provider or DV Clinical Supervisor. *Standards*, Section 9.01 (II), (B) Applicants are required to have DV clinical supervision for a minimum of 1 hour per month for up to 10 client contact hours, and 2 hours per month for 10 or more client contact hours or additional supervision as determined by the DV Clinical Supervisor.

____
(*Name of agency where experience was gained*)

Or (**Optional**): I verify that the applicant has completed this requirement at
Agency____ Dates: __________________________________

Alternate supervisor's signature _____________________________________ Date _______________________

25 face-to-face client contact hours providing clinical substance abuse treatment at an ADAD licensed or comparable program *Standards*, Section 9.01 (II)(D). A CAC I, II or III or LAC will fulfill this requirement, enter CAC number. __________

____
(*Name of agency where experience was gained*)

Or (**Optional**): I verify that the applicant has completed this requirement at
Agency____ Dates:__________________________________

Alternate supervisor's signature ______________________________________ Date ______________________

SECTION I

C. Verification of Ongoing Clinical Supervision

I, ____ do hereby verify that I meet the qualifications of
(DV Clinical Supervisor)

DV Clinical Supervisor as required by the *Standards,* Section 9.03. I further verify that I am providing and will continue to provide supervision for ______________________________________once approved, as required
(Applicant)

by the *Standards,* Section 9.01 for Entry Level Approval. If our supervision ends, I will notify the DVOMB in writing of the date the supervision is terminated.

____ ________________________
(DV Clinical Supervisor's signature) (Date)

SECTION I

D. Verification of Ongoing Co-Facilitation

Reference the Standards, Section 9.01

Directions for Applicant:
Please complete either the top half **or** the bottom half of this form.

Court ordered domestic violence offender treatment shall only be provided by an Approved Provider. Therefore, while an applicant is in training and/or application process, all client face-to-face sessions must be co-facilitated with an Approved Provider. This includes individual sessions, group sessions and evaluations. §16-11.8-104 C.R.S.

I, ____, do hereby verify that I am co-facilitating as required by
(Approved Domestic Violence Treatment Provider)

Standards, Section 9.01 (G) all domestic violence offender treatment, as identified above, with the following applicant:

____.
(Applicant)

I further verify that I will continue to provide co-facilitation for this applicant during their entire application process, which I understand may continue for several months or longer. If I need to discontinue my co-facilitation, I will notify the DVOMB office at 700 Kipling Street, Suite 1000, Denver, CO 80215.

____
(Approved Domestic Violence Treatment Provider's Signature) (Date)

IF YOU ARE NOT CURRENTLY WORKING IN DOMESTIC VIOLENCE OFFENDER TREATMENT, COMPLETE THIS PORTION OF THE FORM

I, ____ do hereby verify that I am not currently working in the
(Applicant)

domestic violence offender treatment field. If I do provide any services for court ordered domestic violence offenders, I will notify the DVOMB immediately and have my co-facilitator complete the top portion of this form.

____
(Applicant's Signature) (Date)

E. DV Offender Treatment Philosophy Statement

Standards, Section 9.07 (a)

Submit your philosophy regarding domestic violence offender treatment. In a one-page statement, please include your viewpoints regarding causal factors of domestic violence, key treatment issues for offenders and victim safety issues. Also include your plan on how you will be maintaining cooperative working relationships within your community in the following areas: domestic violence victim services, other treatment providers, criminal justice programs, alcohol/drug abuse programs and social services. Please keep in mind it is recommended that providers attend community-based task force meetings that may address all the above listed areas.

F. Offender Evaluations

1. Submit two (2) court ordered formal written dv offender evaluations that you, the applicant, have co-facilitated. Please note these are formal written reports, not brief summaries
2. Submit two (2) offender treatment plans that you, the applicant, have designed (on the same clients as identified in the evaluations in item #1 above)
3. Submit two (2) offender contracts that you, the applicant, have designed (on the same clients as identified in items # 1 and 2 listed above).

Evaluations must be formal written summaries containing all required components of Standard 4.0. Copies must be of actual offender evaluations, treatment plans and offender contracts (with client identifying information omitted)

G. Letter from Victim Advocate

Submit a letter from your victim advocate verifying that he/she is currently (or will be once you are approved) providing victim advocacy for your program per the *Standards, Section 7.02*

H. Supervisor Verification

I, ___________________________________, do verify that I have reviewed all of the above-required materials.
(DV Clinical Supervisor's Name)

____ ________________________
(Domestic Violence Clinical Supervisor's signature) (Date)

GENERAL REQUIRED FORMS

Directions for Applicant:

The following is a list of all documentation required for Section II. You must use the forms provided. We have included the required forms unless otherwise indicated. You may use this page for reference and as your checklist to ensure that you are including all of your required documentation.

Required Forms:

A. DORA Verification

B. Contact Information

C. Certification and Licensure

D. Background and Identifying Information

E. Statement of Understanding

F. Criminal Background Information

G. Statements of Compliance

H. Education

I. Fingerprint card (fingerprint card instructions provided)

A. DORA Verification

DEPARTMENT OF REGULATORY AGENCIES (DORA)
VERIFICATION FORM

****

PRINT NAME Last First Middle (Maiden Name)

ADDRESS Street City State Zip

****

I hereby authorize the Department of Regulatory Agencies to release information regarding the status of my license, registration and/or certification, complaints, and any disciplinary actions.

Signature Date

B. Contact Information for Your References

Please list below names, addresses, and phone numbers of the following three (3) references:
(These must be three *different* individuals.) These individuals will be interviewed by our Application Review Coordinator or an investigator.

1. Your clinical domestic violence supervisor
2. The advocate who provides victim advocacy for your program; and,
3. A probation officer with whom you have shared domestic violence cases.
4. Identify the Judicial District you will be working in (*here*) → → ____________________________

1. Name: ______________________________

   Position: ______________________________

   Address: ______________________________

   Office phone: ____________________ Cell Phone: ____________________

   E-Mail Address: ______________________________

---

2 Name: ______________________________

   Position: ______________________________

   Address: ______________________________

   Office phone: ____________________ Cell Phone: ____________________

   E-Mail Address: ______________________________

---

3. Probation Officer Name (also identify judicial district, state or private probation):

   ____

   Position: ______________________________

   Address: ______________________________

   Office phone: ____________________ Cell Phone: ____________________

   E-Mail Address: ______________________________

SECTION II

C. Certification and Licensure

- Have you ever applied for certification to any local domestic violence perpetrator treatment provider certification board? ☐ YES ☐ NO If yes, list dates: ______________________________

Contact person(s)? ______________________________ Please describe the outcome(s): ______________
____

- Do you have a current Colorado license, certification or registration from the Department of Regulatory Agencies to practice psychotherapy? ☐ YES ☐ NO

If yes, please indicate type:

☐ Physician
☐ Social Worker Level _________ (Please specify)
☐ Alcohol & Drug Abuse Counselor, Level ____ (Please specify)
☐ Licensed Addiction Counselor
☐ Unlicensed Database
☐ Other (Please specify) ______________________________
☐ Psychiatric Clinical Nurse Specialist
☐ Licensed Marriage and Family Therapist
☐ Licensed Professional Counselor
☐ Psychologist

- Have you practiced psychotherapy without a license in any other state? ☐ YES ☐ NO

If yes, please list those states ______________________________

- Have you ever been licensed or certified to practice psychotherapy in any other states? ☐ YES ☐ NO

If yes, please list those states and your license ______________________________

- Have you ever been disciplined and/or found to engage in unethical behavior by any licensing or certifying body or professional organization? ☐ YES ☐ NO

If yes, please explain: ______________________________

- Have you ever had a license or certification revoked, suspended, renewal refused, or been placed on probationary status by any professional licensing body? (This includes any previously successful or currently pending challenge to your licensure, certification or registration.) ☐ YES ☐ NO

If yes, please explain: ______________________________

- Have you ever voluntarily relinquished a license or certification to provide psychotherapy, or voluntarily or involuntarily terminated any mental health staff privileges? ☐ YES ☐ NO

If yes, please explain: ______________________________

SECTION II

D. Background and Identifying Information

(Information provided will be used by staff to conduct a criminal history check, background investigation and to document qualifications)

Applicant Name: ____
(You must apply as an individual, not as a program or partnership.)

Maiden Name/other names used: ______________________________________

Gender: ☐ Male ☐ Female Date of Birth: ____________________
(Required for criminal background check)

Social Security Number: ______________________________________
(Required by federal law)

Business Name: ____

Requested information below is public record. For safety reasons, do not use home information

1. Primary Business Information:

____
Street Address City State Zip

Office #: ____________________ Cell #: ____________________ Fax #: ____________________

E-mail Address: ____

Do you have multiple business addresses or phone numbers: ☐ No ☐ Yes (If yes, please list below.)

2. ____
Street Address City State Zip

Office #: ____________________ Cell #: ____________________ Fax #: ____________________

E-mail Address: ____

---

3. ____
Street Address City State Zip

Office #: ____________________ Cell #: ____________________ Fax #: ____________________

E-mail Address: ____

County(ies) of Business Address(es): 1. ________________ 2. ________________ 3. ________________

List languages (other than English) in which you are fluent and will provide treatment (this will be on the Provider List): ____

SECTION II

E. Statement of Understanding

I understand that the information I have submitted for this application to the Domestic Violence Offender Management Board (hereafter Board) for placement on the Approved Provider List will be used for the following purposes:

1. To conduct a criminal history check and a background investigation.
2. To create and disseminate a list of Approved Treatment Providers.
3. To create a database of information on the availability of domestic violence offender treatment services in Colorado.
4. My application materials will become public record of the Division of Criminal Justice and may be subject to the open record act requests pursuant to §24-72-304 C.R.S.
5. The Board will release information regarding the status of my application, my placement on the Approved Provider List and any information regarding any Board decision to remove me from the Approved Provider List or denial of my application for placement on the Approved Provider List to all referring agencies.
6. If any complaints are filed against me, or my services, this application may be re-reviewed.
7. I understand that by applying for approval, I agree to be audited for compliance with the *Standards* when necessary.
8. I understand that any applicant who is denied placement on the Provider List may appeal the decision. Reference: *Standards*, Appendix D-9 Appeals Process
9. I understand that if my name is included erroneously on the Approved Provider List, the Board may remove it without due process.

Inclusion on the Approved Provider List does not constitute certification or licensure and should not be represented as such. It does not create an entitlement or guarantee that I will receive referrals. If I am approved to be on the Approved Provider List, it means that I am eligible to be considered for referral as a provider of treatment services for court ordered domestic violence offenders, pursuant to §16-11.8-104, C.R.S. which states:

> *On or after January 1, 2001, the Department of Corrections, the Judicial Department, the Division of Criminal Justice within the Department of Public Safety, or the Department of Human Services shall not employ or contract with and shall not allow a domestic violence offender to employ or contract with any individual or entity to provide domestic violence offender treatment evaluation or treatment services pursuant to this article unless the individual or entity appears on the approved list developed pursuant to §16-11.8-103(4), C.R.S*

Signature of Applicant: ____ Date ___________________

Name of Applicant (type or print legibly): ____

SECTION II

F. Criminal Background Information

- Have you ever been convicted of, received a deferred judgment for, or pled nolo contender to any offense involving criminal sexual or violent behavior? ☐ YES ☐ NO

If yes, please explain: ____________________

____

____

____

____

- Have you ever been arrested, charged or convicted of any criminal offense? ☐ YES ☐ NO

If yes, please explain: ____________________

____

____

____

____

- Have you ever been convicted of a felony? ☐ YES ☐ NO

If yes, please explain: ____________________

____

____

____

____

SECTION II

G. Statements of Compliance

I have read and understand the *Standards for Treatment with Court Ordered Domestic Violence Offenders* in their entirety and agree to comply with the *Standards*. I have answered all questions on this application fully and my answers are complete and true to the best of my knowledge. I further understand that false statements or material misstatements in this application are cause for non-approval or for removal from the Approved Provider List.

Signature of Applicant: ____

Date ____

Applicant Name (type or print legibly): ____

Research Statement of Compliance

I agree to provide data and documentation as requested by the Domestic Violence Offender Management Board for the purposes of research or evaluation as required by §16-11.8-103 C.R.S. Reference: *Standards*, Section 11.12.

(Please initial) ______________________________

SECTION II

H. Education

Reference the Standards 9.01 1 (A)

Applicant must have a Bachelor's Degree or higher in a human services area of study. The degree must be obtained from a college or university accredited by an agency recognized by the U.S. Department of Education.

Directions for Applicant:

Submit a copy of your transcripts in addition to completing this form

Applicant Name ____

Degree ______________________________ Major _________________________________

College or University ____

SECTION II

I. Fingerprint Card Instructions (page 1)

Colorado Revised Statutes (16-11.8-103 (4) (b) (III) (A) C.R.S.) require that applicants must submit one set of fingerprints for use by the Colorado Bureau of Investigation (CBI) and for transmittal to the Federal Bureau of Investigation (FBI). All new applicants are required to submit a fingerprint card.

The form on the following page is a replica of the fingerprint card that is enclosed.

Please read the instructions below carefully:

1. You must use the fingerprint card that is enclosed. (Do not substitute it for a fingerprint card from your local law enforcement agency.)
2. Take the enclosed card to your local law enforcement agency for fingerprinting. (They will charge you a fee.)
3. Pay close attention to the numbered description of each category that needs to be filled out. Any inaccuracies will result in your card being returned to you which will delay the process and may result in additional fees.
4. Use black ink only.
5. All information written must be contained within each box. Do not write on any blue lines.
6. Do not highlight any information.
7. You must submit your completed fingerprint card (along with an enclosed money order or cashier's check made out to CBI for $39.50) to:

   Dana LaPointe
   Domestic Violence Offender Management Board
   Division of Criminal Justice
   700 Kipling Street, Suite 1000
   Denver, CO 80215

8. Insert information into boxes on fingerprint card according to the **sample** and list on the next two pages.

SECTION II

I. Fingerprint Card Instructions (page 2)

SAMPLE:

APPLICANT

LEAVE BLANK

TYPE OR PRINT ALL INFORMATION IN BLACK
LAST NAME NAM FIRST NAME MIDDLE NAME
(1)

FBI LEAVE BLANK
(21)

SIGNATURE OF PERSON FINGERPRINTED
(12)

ALIASES AKA
(2)

ORI CO030085C
ST DIV CRIM JUST
DENVER, CO

DATE OF BIRTH DOB
Month Day Year
(10)

RESIDENCE OF PERSON FINGERPRINTED
(13)

CITIZENSHIP CTZ
(3) **(3A)**

SEX	RACE	HGT	WGT	EYES	HAIR	PLACE OF BIRTH POB
(4)	**(5)**	**(6)**	**(7)**	**(8)**	**(9)**	**(11)**

DATE **(14)**
SIGNATURE OF OFFICIAL TAKING FINGERPRINTS

YOUR NO. OCA
(20)

LEAVE BLANK

EMPLOYEE AND ADDRESS
(15)

FBI NO. **FBI**

CLASS

ARMED FORCES NO. MNU

REASON FINGERPRINTED
(16)

SOCIAL SECURITY NO. SOC
(17)

REF.

MISCELLANEOUS NO. MNU
(18)

(19)

PLEASE FILL OUT ENCLOSED FINGERPRINT CARD AS FOLLOWS:

1. NAME	Type or print Last, First and Middle Name
2. AKA	Maiden name, other married names or any other name used
3. CITZENSHIP	U.S. (if born in the U.S) or Alien registration number
3A. AMOUNT	DO NOT FILL IN
4. SEX CODES	M (Male) F (Female)
5. RACE CODES	W (White) B (Black) W (Hispanic) I (Indian) A (Asian – Oriental)
6. HEIGHT	Feet and inches (for example 5'6" = 506; 6' = 600)
7. WEIGHT	090,100,250, etc.
8. EYE CODES	BLK (Black), BLU (Blue), BRO (Brown), GRN (Green), GRY (Gray), HAZ (Hazel), XXX (Unknown)
9. HAIR CODES	BAL (Bald), BLK (Black), BRO (Brown), GRY (Gray), RED (Red/Auburn), WHI (White), XXX (Unknown)
10. DOB	Date of Birth
11. POB	Place of Birth

SECTION II

I. Fingerprint Card Instructions (page 3)

12. SIGNATURE	Signature of person fingerprinted – Individual's Signature
13. RESIDENCE	Complete mailing address of person fingerprinted; includes city, state, & zip code
14. DATE	Date Printed; Signature of Law Enforcement Official taking fingerprints
15. EMPLOYER	DO NOT FILL IN
16. REASON PRINTED	DO NOT FILL IN
17. SOC	Social Security Number
18. MISCELLANEOUS	DO NOT FILL IN
19. FINGERPRINTS	All Applicants prints should be taken by a law enforcement agency
20. OCA	DO NOT FILL IN
21. FBI	DO NOT FILL IN