

**COLORADO SEX OFFENDER MANAGEMENT BOARD**

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**2<sup>nd</sup> or SUBSEQUENT  
RE-APPLICATION FOR PLACEMENT  
ON THE  
PROVIDER LIST**

**AS A:**

**FULL OPERATING LEVEL TREATMENT PROVIDER  
AND EVALUATOR for  
*ADULT SEX OFFENDERS AND JUVENILES  
WHO HAVE COMMITTED SEXUAL  
OFFENSES***



**Colorado Department of Public Safety  
Division of Criminal Justice  
Office of Domestic Violence and Sex Offender Management  
Sex Offender Management Board  
700 Kipling Street, Suite 3000, Denver, CO 80215  
Email: [somb@cdps.state.co.us](mailto:somb@cdps.state.co.us)  
<http://dcj.state.co.us/odvsom/>  
Telephone: (303) 239-4526 Fax: (303) 239-4491**

### **Who should complete this application?**

Full Operating Level Treatment Providers and/or Evaluators who are required to renew/update their listing status for the **second or subsequent time** with the Board in order to continue providing services to convicted adult sex offenders and/or adjudicated juveniles who have committed a sexual offense (Sections 4.420 & 4.620 Adult and Juvenile).

Re-applicants who have previously been approved by the Board at the Full Operating Level (2 or more times-initial application and one reapplication) must demonstrate that they continue to meet the qualifications and have a history of compliance with standards of practice contained in *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* and/or the *Standards and Guidelines For The Evaluation, Assessment, Treatment, and Supervision of Juveniles Who Have Committed Sexual Offenses* published by the Sex Offender Management Board (SOMB) and, if applicable, *the Standards for Community Entities That Provide Supervision and Treatment for Adult Sex Offenders who have Developmental Disabilities*. Re-applicants should apply as individuals, not partnerships or programs.

### **How to complete this application:**

- Within the body of this application, you will be asked to document your training and experience, which includes training you may have conducted, and consultation and supervision you may have provided, etc. You may wish to compile these materials in advance.
- When complete, the application should be returned in hard copy to the address on the cover page, “Attention: SOMB”. Save a copy of the completed application and attached documentation for your files.
- Additional copies of the *Standards* or the application materials may be obtained by contacting (303) 239-4526. The *Standards* are also available on the Internet at: [http://dcj.state.co.us/odvsom/sex\\_offender](http://dcj.state.co.us/odvsom/sex_offender). The *Standards* were last updated on 03/28/08.
- Questions may be addressed to Cathy Rodriguez at (303) 239-4499 for questions pertaining to the adult portion of this application and to Kristy Alles-Serrant at (303) 239-4197 for questions pertaining to the juvenile portion of this application.

**Additional Responsibilities if you are placed on the Provider List:**

- To notify the SOMB, in writing of any changes in your name, address, telephone number, program name, program materials or if you have added an additional treatment location. This should be done as soon as possible to avoid administrative problems and accurate placement on the approved provider list.
- To provide the SOMB, in writing, information regarding any changes to your professional status, such as grievances, license revocations, criminal charges/arrest or any other change in your professional standing.

## **GENERAL INSTRUCTIONS**

1. Use the forms provided in this application.
2. Submit ONLY the information requested.
3. Submit the required information **in the order requested.**
4. Follow all instructions carefully as incorrect applications WILL delay the process.
5. **KEEP A COPY OF YOUR COMPLETED APPLICATION AND ATTACHMENTS FOR YOUR FILES.**
6. Please remove pages i through ix before mailing in your completed application and any pages not applicable to your application status.
7. PLEASE DO NOT use staples, paper clips, binders, sheet protectors or other materials because all applications are copied multiple times in their entirety during processing.
8. Please submit all materials on SINGLE-SIDED COPIES .
9. ALL applicants MUST submit a **money order** for **\$100.00** made payable to **Colorado Department of Public Safety.** This is utilized to for the cost of your background check pursuant to C.R.S. and current Standards.

## **Which application pages should I fill out and submit?**

- There is a grid on the next page to assist you in this process.
- If you are applying for multiple listings, please note that only ONE copy of each requested item is required.

*Compliance with the Standards will be assessed over time through a periodic renewal process, a monitoring process, and a mechanism to receive and investigate complaints within the policies established for such complaints.*



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**APPLICANT NAME:**

**DATE:**

**Provider #:**  
(SOMB use only)

**Adult and Juvenile 2<sup>nd</sup> and Subsequent Re-Application:**

**For Continued Placement on the Sex Offender Management Board's Provider List as a Full Operating Level Treatment Provider and/or Evaluator.**

**Please check the category(ies) for which you are re-applying:**

- ADULT TREATMENT PROVIDER**
  - \_\_\_ **FULL OPERATING LEVEL**
  - \_\_\_ **DEVELOPMENTAL DISABILITIES SPECIALTY**
  
- ADULT EVALUATOR**
  - \_\_\_ **FULL OPERATING LEVEL**
  - \_\_\_ **DEVELOPMENTAL DISABILITIES SPECIALTY**
  
- JUVENILE TREATMENT PROVIDER**
  - \_\_\_ **FULL OPERATING LEVEL**
  
- JUVENILE EVALUATOR**
  - \_\_\_ **FULL OPERATING LEVEL**

**SECTION ONE**  
**Background and Identifying Information:**  
***Adult and Juvenile Re-Applicants***

This information will be used by SOMB staff to conduct a criminal history check, a background investigation, and to document your qualifications.

Applicant Name: \_\_\_\_\_  
Credentials (MA, LCSW, etc) \_\_\_\_\_  
Aliases: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_

***PLEASE NOTE THAT FOR LISTING PURPOSES EMPLOYER NAME, ADDRESS, AND TELEPHONE NUMBER WILL BE USED. FOR SAFETY REASONS, THE USE OF HOME ADDRESSES AND TELEPHONE NUMBERS IS UTILIZED BY STAFF ONLY.***

Employer Name: \_\_\_\_\_

Primary Business Address: \_\_\_\_\_  
\_\_\_\_\_

County of Primary Location: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

You may list up to five addresses and counties on the provider list. Please list both the address and the **county**.

- 1. \_\_\_\_\_ County: \_\_\_\_\_
- 2. \_\_\_\_\_ County: \_\_\_\_\_
- 3. \_\_\_\_\_ County: \_\_\_\_\_
- 4. \_\_\_\_\_ County: \_\_\_\_\_
- 5. \_\_\_\_\_ County: \_\_\_\_\_

**Please list languages, other than English, which you speak fluently and in which you can demonstrate clinical proficiency (*this information will be published on the Provider List*):**

\_\_\_\_\_  
\_\_\_\_\_

**Authorization for Release of Information:  
*Adult and Juvenile Re-Applicants***

I, \_\_\_\_\_, authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to be on the Sex Offender Management Board's Provider List as one or more of the following: **Full/Associate Operating Level Treatment Provider, Full/Associate Operating Level Evaluator, Full/Associate Operating Level Polygraph Examiner.** I agree to give any further information that may be required in reference to my past record.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court association, or institutions having possession of any documents, records or other information pertaining to me, to furnish to the Sex Offender Management Board such information, including, but not limited to, documents and records, informal, pending or closed, or any other pertinent data and to permit the Sex Offender Management Board or any of its designated officers, committees, or staff to inspect and make copies of such documents, records and other information in connection with this application.

The foregoing authorization for release of information or records does not include consent for release of personal financial records, bank accounts, loans or other such personal information not related to my moral character, professional reputation, or fitness as a treatment provider and/or evaluator and/or polygraph examiner.

I hereby release, discharge and exonerate the Sex Offender Management Board, its agents and representatives, and any person furnishing such information from any and all liability of every nature and kind arising out of the furnishing of such information to other medical or professional societies or organizations, hospitals and hospital committees, and government agencies in the event that other such organizations and agencies present to the Sex Offender Management Board a release of authorization for release of information executed by me or a facsimile of such release or authority executed by me.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Clearly Printed Applicant Name

\_\_\_\_\_  
Date

## ***Adult and Juvenile Re-Applicants:***

**Please list your place(s) of employment and positions for the last five years starting with your current or most recent employment. If you practiced psychotherapy in another state, with or without a license, please also include that work experience. You may substitute a professional resume if it provides all the information requested.**

*You may copy this page*

|  |  |
|--|--|
| <i>Employer/Business Name:</i>   | <i>Telephone:</i>                                    |
| <i>Street Address:</i>   |  |
| <i>City:</i>   | <i>State:</i> <i>Zip Code:</i>                       |
| <i>Position:</i>   | <i>Dates of Employment:</i><br><i>From</i> <i>To</i> |
| <i>Unless you were self-employed, list supervisor name:</i>                                      | <i>Telephone:</i>                                    |
| <i>If self-employed, provide the name of a professional reference to verify this employment:</i> | <i>Telephone:</i>                                    |
| <i>Summary of job duties:</i>  |  |
| <i>Reason for leaving:</i>   |  |

|  |  |
|--|--|
| <i>Employer/Business Name:</i>   | <i>Telephone:</i>                                    |
| <i>Street Address:</i>   |  |
| <i>City:</i>   | <i>State:</i> <i>Zip Code:</i>                       |
| <i>Position:</i>   | <i>Dates of Employment:</i><br><i>From</i> <i>To</i> |
| <i>Unless you were self-employed, list supervisor name:</i>                                      | <i>Telephone:</i>                                    |
| <i>If self-employed, provide the name of a professional reference to verify this employment:</i> | <i>Telephone:</i>                                    |
| <i>Summary of job duties:</i>  |  |
| <i>Reason for leaving:</i>   |  |

## Adult and Juvenile Re-Applicants:

You may substitute a professional resume if it provides all the information requested.

| ACADEMIC DEGREE            | SPECIALTY AREA | DATE OF DEGREE | NAME OF COLLEGE OR UNIVERSITY | LOCATION-CITY & STATE |
|----------------------------|----------------|----------------|-------------------------------|-----------------------|
| B.A./B.S.                  |                |                |                               |                       |
| M.A., M.S., M.S.W.         |                |                |                               |                       |
| Ed.D.                      |                |                |                               |                       |
| Ph.D.                      |                |                |                               |                       |
| Psy.D.                     |                |                |                               |                       |
| Psychiatric Clinical Nurse |                |                |                               |                       |
| M.D.                       |                |                |                               |                       |
| Board Certified:           | ___ Yes ___ No |                |                               |                       |
| Other (describe)           |                |                |                               |                       |

## Adult and Juvenile Applicants:

- Have you ever received a written reprimand at any place of employment?  
 NO  YES If yes, please explain.

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- Have you ever been suspended, fired, or asked to resign from a position or employment?  
 NO  YES If yes, please explain. You may attach a statement if necessary.

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- Have you ever been convicted of, or received a deferred judgment for, any offense involving criminal sexual or violent behavior?  
 NO  YES If yes, please explain.

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- Have you ever been arrested, charged or convicted of any criminal offense?  
 NO  YES If yes, please explain.

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- Have you ever been convicted of a felony?  
 NO  YES If yes, please explain.

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# ***Adult and Juvenile Re-Applicants for TREATMENT PROVIDER and EVALUATOR:***

Reference: Adult and Juvenile Standards, sections 2.000, 3.000 and 4.000.

- Do you have a current Colorado license to practice psychotherapy?  
 **NO**       **YES**  
(A copy of your license must be attached to this application sections 12-43-303; 12-43-403; 12-43-503; 12-43-603 C.R.S.)

- Have you ever been licensed or certified to practice psychotherapy in any other states?  
 **NO**       **YES** (If Yes, please list those states and include this experience on the employment history page.)

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- Have you ever been found to engage in unethical behavior by any licensing or certifying body in Colorado or any other state or jurisdiction?  
 **NO**       **YES** If yes, please explain.

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- Have you ever had a license or certification revoked, canceled, suspended or have you 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.  
 **NO**       **YES** If yes, please explain.

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- Have you ever voluntarily relinquished a license or certification to provide psychotherapy?  
 **NO**       **YES** If yes, please explain.

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- Have you ever voluntarily or involuntarily limited, reduced or lost any clinical or mental health staff privileges?

**NO**                       **YES** If yes, please explain.

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- Do you have any pending professional liability or malpractice actions, or final judgments or settlements involving your professional practice?

**NO**                       **YES** If yes, please explain.

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## SECTION TWO: Qualifications for Re-Application as Treatment Provider *Adult and Juvenile Applicants*

Reference: Adult and Juvenile Standards, Sections 4.000

The following checklist will help you determine if this application applies to you.

|  | <b>Full Operating Level</b>  |
|--|--|
|  | ___ Licensed and in good standing with licensing board? [Section 4.420 (A)]  |
|  |  |
|  | ___ Active in field through clinical experience, supervision, administration, research, training, teaching, consultation, and/or policy development? [Section 4.420 (B)] |
|  | ___ 40 hours of specialized training in the past 3 years? [Section 4.420 (C)]  |
|  | ___ No history of criminal sexual or violent behavior or felony which would bring into question competence or integrity to treat sex offenders? [Section 4.420 (E)]      |
|  | <b><i>If you answered yes to ALL the questions above, please continue.</i></b>   |

*If you meet all of the previous criteria for **Re-Application as Adult and Juvenile Treatment Provider**, please submit the following:*

- ❑ **\$100.00 money order made out to Colorado Department of Public Safety enclosed (REQUIRED).**
- ❑ **Evidence of licensure**

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# SECTION THREE

## Statement of Understanding

### Adult and Juvenile Re-Applicants

1. I understand that the information I have submitted on this application for the Sex Offender Management Board Provider List will be used for the following purposes:
  - A. To conduct criminal history checks and background investigations as necessary.
  - B. To create and disseminate a provider list of treatment providers, evaluators, and/or polygraph examiners.
2. My application materials will become a public record of the Division of Criminal Justice and may be subject to open record act requests pursuant to Section 24-72-304, C.R.S.
3. Inclusion on the 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 Provider List, it means that I am eligible to be considered as a provider of evaluation, assessment, treatment, and/or behavioral monitoring services for convicted sex offenders and/or adjudicated juveniles who have committed a sexual offense, pursuant to Section 16-11.7-106, C.R.S. which states:

*“(1) The department of corrections, the judicial department, the division of criminal justice of the department of public safety, or the department of human services shall not employ or contract with and shall not allow a sex offender to employ or contract with any individual or entity to provide sex offender evaluation or treatment services pursuant to this article unless the sex offender evaluation or treatment services to be provided by such individual or entity conforms with the standards developed pursuant to Section 16-11.7-103(4) (b).”*

*(2) The board shall require any person who applies for placement on the list of persons who may provide sex offender treatment services pursuant to this article to submit a complete set of his or her fingerprints. The board shall forward any such fingerprints received pursuant to this subsection (2) to the Colorado bureau of investigation for use in conducting a state criminal history record check and for transmittal to the federal bureau of investigation for a national criminal history record check. The board shall use the information obtained from the state and national criminal history record check in determining whether to place the person on the approved provider list.*
4. The Sex Offender Management Board will release information to all referring agencies regarding the status of my application, my placement on the Provider List, founded complaints, removal from the Provider List or denial of my application to the Provider List.
5. In the event a complaint is filed against me, the contents of my application will be reviewed by the Sex Offender Management Board in accordance with the Sex Offender Management Board Administrative Policies.
6. I have read the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders and/or the Standards and Guidelines for the Evaluation, Treatment, and Supervision of Juveniles Who Have Committed Sexual Offenses and/or Standards for Community Entities That Provide Supervision and Treatment for Adult Sex Offenders Who Have Developmental Disabilities* in its entirety, and agree to carry out the *Standards* to the best of my ability related to the listing and level for which I am applying. I have answered all questions on this application honestly and the answers are complete to the best of my knowledge. I further understand that false statements or misstatements on this application are grounds for removal from the SOMB Provider Lists.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Applicant: \_\_\_\_\_

# SECTION FOUR

## References

### *Adult and Juvenile Re-Applicants*

#### References

The individuals provided as references must be familiar with your professional qualifications. The references are divided into two sections (1A-3A are professional references and 1B-3B are MDT/CST members). Please note that at least two (2) of the references listed in 1B-3B must be members of a Community Supervision Team and/or Multidisciplinary Teams in which you participate. DOC/DYC employees please refer to \* note below. **Letters of reference are NO longer required** as four of the following six references will be randomly contacted by our background investigator.

**If you are not providing direct clinical services, please submit six references familiar with your work as it pertains to your work in the field of sex offender treatment and/or evaluation.**

1A. Name:

Position:

Address:

Telephone number:

2A. Name:

Position:

Address:

Telephone number:

3A. Name:

Position:

Address:

Telephone number:

**REQUIRED ADDITIONAL REFERENCES** - These references must be familiar with your offense-specific work.

1B. PROBATION/PAROLE OFFICER

Name:

Address:

Telephone number:

2B. VICTIM ADVOCATE, THERAPIST, OR OTHER VICTIM PROFESSIONAL

Name:

Address:

Telephone number:

3B POLYGRAPH EXAMINER, TREATMENT PROVIDER, EVALUATOR, SUPERVISING OFFICER OR OTHER (Please indicate the individual's profession below)

Name:

Profession:

Address:

Telephone number:

\* DOC/DYC EMPLOYEES: Since you may not be working with Community Supervision Teams and/or Multidisciplinary Teams you may provide names of co-workers or others familiar with your professional qualifications.

# SECTION FIVE

## Specialized Training

### *Adult and Juvenile Re-Applicants*

Continuing education is essential in staying active in the field. Training attendance over the past three years will be considered.

**Conferences and Workshops:** Generally the length of the workshop or training equals hours of training. FOR CONFERENCES, YOU MUST ITEMIZE EACH WORKSHOP ON A SEPARATE LINE. Video training counts for half the hours of the actual training.

**Although you are no longer required to submit copies of your training certificates and/or agendas, you may be required to submit these upon request. The SOMB will randomly audit provider training certificates.**

**Designation:** In the column below, please indicate the area your training counts towards as follows:

Both: ("V") Victim, ("SOS") Sex Offense Specific, ("E-SOS") Evaluation

Juvenile: ("JT") Juvenile Treatment, ("GT") General Treatment

Adult: ("ASO") Treatment of Adult Sex Offenders

*You may copy this page.*

| DATES  | HOURS | TITLE OF TRAINING          | SPONSOR/TRAINER                | Area:<br>(e.g. "V", "SOS", "JT",<br>"GT", "ASO", "E-SOS", or DD) | Adult or Juvenile<br>(e.g. "A", "J") |
|--------|-------|----------------------------|--------------------------------|--|--------------------------------------|
| 1/4/02 | 6     | <i>Offender Typologies</i> | <i>I. M. A Trainer, L.P.C.</i> | SOS  | J, A                                 |
|        |       |                            |                                |  |                                      |
|        |       |                            |                                |  |                                      |
|        |       |                            |                                |  |                                      |
|        |       |                            |                                |  |                                      |
|        |       |                            |                                |  |                                      |
|        |       |                            |                                |  |                                      |
|        |       |                            |                                |  |                                      |
|        |       |                            |                                |  |                                      |
|        |       |                            |                                |  |                                      |

# SECTION SIX

## Clinical Experience

### *Adult and Juvenile Re-Applicants*

This form is to be used for documentation of the number of hours you have accumulated within the last three (3) years by providing treatment, evaluation, training, teaching, consultation, administration, supervision, policy development, conducting research, etc. (Please refer to the Standards for Second and Subsequent Applicants for the minimum number of required hours needed for the listing(s) for which you are applying.) Please clearly specify if your hours are alternative to clinical work (i.e. case consultation, administration, etc.) **Please only fill out the section that is relevant to which area you are applying for. If you are applying for both Adult and Juvenile, please fill out both sections.**

*You may copy this page.*

#### ADULT CLINICAL EXPERIENCE

| DATES | # of hours,<br>or # of evals. | CLINICAL ACTIVITY TYPE<br><i>(Group therapy, polygraph examinations, sex<br/>offense- specific evaluations, face to face, etc.)</i> | LOCATION<br>or<br>AGENCY |
|-------|-------------------------------|---|--------------------------|
| From: |                               |   |                          |
| To:   |                               |   |                          |
| From: |                               |   |                          |
| To:   |                               |   |                          |
| From: |                               |   |                          |
| To:   |                               |   |                          |
| From: |                               |   |                          |
| To:   |                               |   |                          |

#### JUVENILE CLINICAL EXPERIENCE

| DATES | # of hours,<br>or # of evals. | CLINICAL ACTIVITY TYPE<br><i>(Group therapy, polygraph examinations, sex<br/>offense- specific evaluations, face to face, etc.)</i> | LOCATION<br>or<br>AGENCY |
|-------|-------------------------------|---|--------------------------|
| From: |                               |   |                          |
| To:   |                               |   |                          |
| From: |                               |   |                          |
| To:   |                               |   |                          |
| From: |                               |   |                          |
| To:   |                               |   |                          |
| From: |                               |   |                          |
| To:   |                               |   |                          |

## **SECTION SEVEN**

### **Standards of Practice for *Adult and Juvenile Treatment Providers*: Full Operating Level Re-Applicants**

#### **Attachments:**

- a. If you are presently working in a non-clinical position, please provide a written description of your job duties and how you are staying current in the field.
- b. If you are currently providing clinical services, please attach copies of two (2) RECENT representative sex offense-specific treatment plans, with client identifying information *deleted*, that include the information required in Standards.

## SECTION EIGHT

### Qualifications for Re-Application as Evaluator

#### *Adult and Juvenile Applicant*

Reference: Standards.

**The following checklist will help you determine if you qualify. Please note that pursuant to Section 4.260 (B), an evaluator who meets the following criteria is NOT required to continue listing as a Full Operating Level Treatment Provider.**

|  | <b>Full Operating Level</b>   |
|--|---|
|  | ___ Active in field through clinical experience, supervision, administration, research, training, teaching, consultation, or policy development? [Section 4.620 (B)]  |
|  | ___ 10 of the 40 hours of specialized training shall be specific to the sex offense specific evaluation of adult sex offenders? [Section 4.620 (C)]   |
|  | ___ No history of criminal sexual or violent behavior or felony which would bring into question the competence or integrity of the individual to provide sex offenses evaluations to sex offenders? [Section 4.620 (E)] |
|  | ___ Licensure or certification. [Section 4.620 (A)]   |
|  | <i><b>If the answers to ALL of the above questions, please continue.</b></i>  |

*If you meet all of the previous criteria for **Re-Application as Adult and/or Juvenile Full Operating Level Evaluator**, please submit the following:*

- ❑ **\$100.00 money order made out to Colorado Department of Public Safety enclosed (only one is necessary regardless of how many categories of re-application are being submitted)**
- ❑ **Evidence of licensure**

**SECTION # PAGE #**

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(including required attachments) ..... 17**

## **SECTION NINE**

### **Standards of Practice for *Adult and Juvenile Evaluator:* Full Operating Level Re-Applicants**

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#### **Attachments:**

- a. If you are presently working in a non-clinical position and not conducting evaluations, please provide a written description of your job duties and how you are staying current in the field. (This is only required once in the application but should include all facets of re-application categories.)
- b. If you are currently conducting evaluations, please attach copies of two (2) sex offense-specific evaluations conducted on convicted adult sex offenders, with client identifying information deleted, that include the information required in Section 2.000.

**SECTION TEN**  
**Qualifications of Adult *Treatment Providers* re-applying as Specialty in Treatment of Sex Offenders with Developmental Disabilities (DD)**

Please use this checklist to determine if you meet the conditions to reapply for the DD Specialty.

|  | <b>Full Operating Level Treatment Provider</b>  |
|--|---|
|  |   |
|  | ___ 10 out of the required 40 hours of specialized training must address aspects of working with DD sex offenders. [Section DD 4.420 (C)] |
|  | <i>If you answered yes, please continue.</i>  |

## **Standards of Practice for *Treatment Providers* with a Specialty in Treatment of Sex Offenders with Developmental Disabilities (DD)**

Reference: Standards, 3.000

### **Attachments:**

- a. If you are presently working in a non-clinical position, please provide a written description of your job duties and how you are staying current in the field. (This is only required once in the application but should include all facets of re-application categories.)
- b. If you are currently providing clinical services, please describe how your treatment of sex offenders with developmental disabilities differs from your treatment of sex offenders without developmental disabilities. Please limit your response to one page.
- c. If you are currently providing clinical services, please attach at one (1) representative treatment plan, signed by you, conducted on a sex offender with developmental disabilities with all client identifying information deleted.

## SECTION ELEVEN

# Qualification of Adult *Evaluators* Reapplying as Specialty in the Evaluation of Sex Offenders with Developmental Disabilities (DD)

Reference: Standards, section DD4.500

Please use this checklist to determine if you meet the conditions to apply for the DD Specialty.

| Associate Level Evaluator | Full Operating Level Evaluator  |
|---------------------------|---|
|                           |   |
|                           | ___ 10 of the 40 required hours of specialized training must address aspects of working with DD sex offenders. [Section DD 4.620 (C)] |
|                           | <i>If you answered yes, please continue.</i>  |

## **Standards of Practice for *Evaluators* with a Specialty in the Evaluation of Sex Offenders with Developmental Disabilities (DD)**

### **Attachments:**

- a. If you are presently working in a non-clinical position, please provide a written description of your job duties and how you are staying current in the field. (This is only required once in the application but should include all facets of re-application categories.)
- b. If you are currently conducting DD evaluations, please describe how your mental health sex offense-specific evaluations of sex offenders with developmental disabilities differ from your mental health sex offense-specific evaluations of sex offenders without developmental disabilities. Please limit your response to one page.
- c. If you are currently conducting DD evaluations, please attach a copy of one (1) representative evaluation for a sex offender with developmental disabilities. Please delete all identifying client information