

**COLORADO SEX OFFENDER MANAGEMENT BOARD**

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**SUPPLEMENTAL APPLICATION  
FOR:**

**LISTED PROVIDERS  
SEEKING PLACEMENT  
ON THE  
JUVENILE PROVIDER LIST/or  
ADULT PROVIDER LIST**



**Colorado Department of Public Safety  
Division of Criminal Justice  
Office of Domestic Violence and Sex Offender Management  
700 Kipling Street, Suite 3000, Denver, CO 80215  
dcj.state.co.us/odvsom  
Phone: (303) 239-4199 Fax: (303) 239-4491**

**YOU MAY USE THIS GRID TO HELP DETERMINE WHICH SECTIONS OF THIS APPLICATION TO COMPLETE**

**COMPLETE THE SECTIONS MARKED WITH AN "X"**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Exemption Clause – Treatment Provider: Juvenile Full Operating Level	X	X	X	X	X	X	X		X									X
Exemption Clause – Evaluator: Juvenile Full Operating Level	X	X	X	X	X	X		X			X							X
Treatment Provider: Juvenile Full Operating Level	X	X	X	X	X	X			X									
Treatment Provider: Juvenile Associate Level	X	X	X	X	X	X				X								X
Evaluator: Juvenile Full Operating Level	X	X	X	X	X	X					X							
Evaluator: Juvenile Associate Level	X	X	X	X	X	X						X						X
Polygraph Examiner: Juvenile Full Operating Level	X	X	X	X	X	X							X					
Polygraph Examiner: Juvenile Associate Level	X	X	X	X	X	X								X				X
Plethysmograph Examiner: Juvenile	X	X	X	X	X										X			
Abel Assessment Examiner: Juvenile	X	X	X	X	X	X										X		

**ALL applicants must complete a Standards of Practice section for each area of listing requested. Standards of Practice forms are contained in each categorized section.**

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## **Applicant Category**

ALL APPLICANTS

**APPLICANT NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**Provider #:** \_\_\_\_\_

(SOMB Use Only)

### **SUPPLEMENTAL APPLICATION For:**

**Providers already listed on the Sex Offender Management Board Adult Provider List OR Juvenile Provider List seeking placement on the Juvenile Provider List or Adult Provider List as a *Treatment Provider, Evaluator, or Polygraph Examiner***

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

- Treatment Provider: Juvenile - Full Operating Level**
- Treatment Provider: Juvenile - Associate Level**
- Evaluator: Juvenile - Full Operating Level**
- Evaluator: Juvenile - Associate Level**
- Polygraph Examiner: Juvenile - Full Operating Level**
- Polygraph Examiner: Juvenile - Associate Level**

**SECTION ONE**  
**Background and Identifying Information**

ALL APPLICANTS

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

Date of Birth: \_\_\_\_\_

Are you on the Approved Provider List of the Colorado Domestic Violence Offender Management Board (DVOMB)? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you submitted a finger print card to the DVOMB? \_\_\_\_\_ Yes \_\_\_\_\_ No

*PLEASE NOTE THAT ALL ADDRESSES AND TELEPHONE NUMBERS BECOME A MATTER OF PUBLIC RECORD. FOR SAFETY REASONS, USE OF HOME ADDRESSES AND TELEPHONE NUMBERS IS NOT RECOMMENDED.*

Employer or Business Name and Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Counties in which you provide services: \_\_\_\_\_

\_\_\_\_\_

(If applicable, please list on a separate piece of paper all of the additional addresses, telephone numbers, faxes, & emails for the other locations where you provide services.)

## Authorization for Release of Information

I, \_\_\_\_\_, authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to be on the Provider List as a **Full Operating Level Treatment Provider** or as an **Associate Level Treatment Provider** and/or as a **Full Operating Level Evaluator** or as an **Associate Level Evaluator** and/or as a **Full Operating Level Polygraph Examiner** or as an **Associate Level Polygraph Examiner** by the Sex Offender Management Board. 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 clinical 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

## SECTION TWO

### Application Checklist

ALL APPLICANTS

#### PLEASE CHECK THE APPROPRIATE BOXES

If you are currently on the Adult Provider List as a:	Then you may use <u>this application</u> to apply for:
<input type="checkbox"/> TREATMENT PROVIDER at the Full Operating Level	<input type="checkbox"/> TREATMENT PROVIDER: JUVENILE at Full Operating Level <b>OR</b> <input type="checkbox"/> TREATMENT PROVIDER: JUVENILE at the Associate Level
<input type="checkbox"/> TREATMENT PROVIDER at the Associate Level	<input type="checkbox"/> TREATMENT PROVIDER: JUVENILE at the Associate Level
<input type="checkbox"/> EVALUATOR at the Full Operating Level	<input type="checkbox"/> EVALUATOR: JUVENILE at Full Operating Level <b>OR</b> <input type="checkbox"/> EVALUATOR: JUVENILE at the at the Associate Level
<input type="checkbox"/> EVALUATOR at the Associate Level	<input type="checkbox"/> EVALUATOR: JUVENILE at the Associate Level
<input type="checkbox"/> CLINICAL POLYGRAPH EXAMINER at the Full Operating Level	<input type="checkbox"/> POLYGRAPH EXAMINER: JUVENILE at Full Operating Level <b>OR</b> <input type="checkbox"/> POLYGRAPH EXAMINER: JUVENILE at the Associate Level
<input type="checkbox"/> CLINICAL POLYGRAPH EXAMINER at Associate Level	<input type="checkbox"/> POLYGRAPH EXAMINER: JUVENILE at the Associate Level



# SECTION SIX

## Clinical Experience

### ALL APPLICANTS

This form is to be used for documentation of the number of hours you have accumulated by providing treatment, evaluation/assessment, and polygraphs. Please refer to the Juvenile Standards Sections 4.100(B), 4.200(B), 4.300(C), 4.400(B), 4.600(E), and/or 4.620(B) for the minimum number, and the distribution of required hours needed for the listing(s) for which you are applying. Polygraph Examiners: you must use a separate line for each category of polygraph exam you have completed as required in Sections 4.600 (B) and 4.620(B).

*You may copy this page.*

DATES	# of hours, or # of evals., or # of exams	CLINICAL ACTIVITY TYPE <i>(e.g. individual therapy, group therapy, maintenance polygraph exams, sex offense specific evaluations)</i>	LOCATION or AGENCY
From: 1/4/02 To: 12/31/02	500 hours	<i>Individual therapy with JVSO</i>	<i>JVSO, Inc.</i>
From:			
To:			
From:			
To:			
From:			
To:			
From:			
To:			
From:			
To:			

## SECTION SEVENTEEN Professional Supervision Agreement

FOR ASSOCIATE LEVEL TREATMENT PROVIDERS AND/OR  
EVALUATORS AND THOSE APPLYING UNDER THE  
EXEMPTION CLAUSE

Reference: Juvenile Standards, Section 4.210, 4.410 and 4.811.

*You may copy this page.*

**APPLICANT'S NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**SUPERVISOR'S NAME:** \_\_\_\_\_

**AGENCY:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**TELEPHONE #:** \_\_\_\_\_

**FAX:** \_\_\_\_\_

**Please complete BOTH boxes**

I, \_\_\_\_\_ do hereby verify that I have provided \_\_\_\_\_ hours  
(Professional Supervisor) (#)

of professional supervision as required by the Juvenile Standards. These supervision hours

were provided at: \_\_\_\_\_

(Agency Name)

between \_\_\_\_\_ and \_\_\_\_\_

(Start Date)

(End Date *or* Today's Date)

These hours consisted of \_\_\_\_\_ hours of group supervision,

\_\_\_\_\_ hours of individual supervision and \_\_\_\_\_ hours of other

types of supervision (please specify \_\_\_\_\_).

**All Associate Level Treatment Providers and Evaluators must fill out this box.** For those applying under the exemption clause, if you have contracted for clinical supervision or for professional supervision services, please fill out this box.

We agree to accumulate the required professional supervisory hours as prescribed in the Juvenile Standards. This supervision will consist of \_\_\_\_\_ hours a month of supervision directly related to sex offense specific treatment/evaluation and will include the following types of supervision: \_\_\_\_\_.

**Clinical Supervisor's signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Applicant's signature:** \_\_\_\_\_ **Date** \_\_\_\_\_