IDAHO

PSYCHOSEXUAL EVALUATOR INITIAL

CERTIFICATION APPLICATION INFORMATION
AND INSTRUCTIONS

Procedures for Idaho Psychosexual Evaluator Certification are now in effect.

Please note the following:

- Idaho Certified Psychosexual Evaluators must maintain at least masters-level Idaho professional licensure in a mental health field, or as a medical doctor. Provisional/Supervised-level providers required to be in the process of obtaining their masters-level Idaho professional licensure if they aren't already licensed.
- Psychosexual evaluations submitted to the court for sentencing purposes must be in the format adopted by the SOMB. Psychosexual evaluations submitted in any other format are not considered to be in conformance with the new standards.
- The application processing fee for initial certification is $75 for Senior/Approved and Associate/Supervised level psychosexual evaluators. The application processing fee for Provisional/Supervised level providers is $50. Evaluators who also wish to be certified as treatment providers will be assessed a separate application processing fee for each provider type. Only checks or money orders made payable to the Sexual Offender Management Board can be accepted.
- An attachment checklist can be found on the last page of the application to assist you in ensuring that the required documentation is included.
- Information about provider qualifications and service standards is located in the SOMB's Standards and Guidelines for Adult Sexual Offender Management which are posted on the SOMB's website (http://somb.idaho.gov).

Rosters for certified providers are posted on the SOMB's website. If you wish to be included for service districts other than the location of your practice's office, please indicate the additional service districts on the application. You must be willing to travel to the districts you indicate.

The SOMB typically meets on the 2nd Friday of each month. To be considered for certification review during any given month, your completed application and any required supporting documentation must be received by the SOMB no less than 30 days prior to a regularly scheduled meeting date.

Please mail your completed application and attachments to:

SOMB Application
Attn: Accounts Receivable
Idaho Department of Correction
1299 N Orchard St, Ste 110
Boise, ID 83706

Questions may be directed to the SOMB office.

SEXUAL OFFENDER MANAGEMENT BOARD
IDAHO DEPT. OF CORRECTION CLINICAL SERVICES ANNEX
3125 S. SHOSHONE ST ♦ BOISE, ID ♦ 83705
TEL: 954-8511 ♦ FAX: 954-8519

FOR OFFICE USE ONLY	
DATE RECEIVED	ISSUANCE DATE
CERTIFICATE #	

IDAHO PSYCHOSEXUAL EVALUATOR
INITIAL CERTIFICATION APPLICATION – ADULT SERVICES

Check All That Apply:

- ☐ Senior/Approved Psychosexual Evaluator
- ☐ Associate/Supervised Psychosexual Evaluator
- ☐ Provisional/Supervised Psychosexual Evaluator
- ☐ Reciprocity Consideration
- ☐ Evaluator Conditional Waiver

Please Type or Print Clearly – Carefully follow all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all supporting documents. Failure to do so could result in a delay in processing or denial of your application. ***Refer to the certification requirements and application procedures outlined in the Idaho SOMB's Standards and Guidelines for Adult Sexual Offender Management.***

DEMOGRAPHIC INFORMATION

Applicant's Name: Last	First	Middle Initial

Business Name & Address 1	Telephone	
City	State	ZIP
Mailing Address if Different from Above	Alternate Telephone	
City	State	ZIP
Business Name & Address 2	Telephone	
City	State	ZIP

Gender ☐ Female ☐ Male	Date of Birth	E-mail Address

List Any Other Names You Have Been Known Under

Which Judicial Districts Would You Like to be Listed Under on the Psychosexual Evaluator Roster?

LICENSURE INFORMATION

Current and Previous Licensure or Certification – List all states where certificates or licenses are or were held. Specifically list certificates or licenses granted as temporary, reciprocity, exemption or similar, with type, date, grantor, and if certificate(s) or license is current. **Idaho's law for psychosexual evaluator certification requires Idaho licensure.**

State/ Jurisdiction	Profession	Grantor	Certificate or License		Permanent, Temporary or Other:explain	Currently Valid: (explain if not valid)
			Yr Issued	Number		

State/ Jurisdiction	Profession	Grantor	Certificate or License		Permanent, Temporary or Other: explain	Currently Valid: (explain if not valid)
			Yr Issued	Number		

EDUCATION INFORMATION

Highest degree earned_____ Year_____
In the spaces below, provide a chronological listing of your post-secondary education and post-graduate training. (Attach additional sheet if necessary.)

Full Name, City and State Schools Attended	Attendance		Date Graduated	Degree Earned	Major Area of Study	If No Degree, # of Semester/Qtr Hrs Earned
	Entrance Date	Ending Date				

PROFESSIONAL EXPERIENCE

List all professional experience in chronological order. (Exclude activities listed under other sections.) (Attach additional sheet if necessary.)

Indicate Nature of Experience or Practice and Location	Inclusive Dates of Experience	
	Beginning Date	Ending Date

Persons certified by the SOMB to conduct or assist with the conduct of psychosexual evaluations in Idaho are expected to conduct testing in accordance with their licensing body, qualifications and experience**. Please provide verification or an explanation of your qualifications to conduct the applicable testing for psychosexual evaluations or whether another qualified person conducts testing for you.** A list of *psychological testing qualifications* as required by testing distributors is appended to the SOMB's Standards and Guidelines for Adult Sexual Offender Management.

PROFESSIONAL EXPERIENCE/SPECIALIZED TRAINING REQUIREMENT

Senior/Approved Certified Psychosexual Evaluator:

1. You must have completed a combination of direct clinical practice with adult sexual offenders and received specialized training for a minimum of 1500 hours within the 3 years immediately preceding this application.
2. Of the 1500 hour clinical practice and specialized training requirement:
   a. At least 500 hours in sexual offender evaluation experience;
   b. May include clinical practice hours in adult sexual offender treatment;
   c. A minimum of 60 hours or a maximum of 375 hours in sexual offender-specific specialized training;
      i. No more than 16 training hours may be attributed to the treatment of sexual abuse victims.
      ii. Must include a minimum of 30 hours in sexual offender assessment and evaluation.
      iii. No more than 300 hours may be attributed to supervised case staffing/planning or crisis management.

Examples:		
Psychosexual evaluations	500 hours	
Specialized training	375 hours	(including at least 30 hours in sexual offender assessment and evaluation)
sexual offender treatment	625 hours	(no more than 300 hours of case staffing or crisis management may be counted)
Total:	1500 hours	

Or:		
Psychosexual evaluations	800 hours	
Specialized training	60 hours	(including at least 30 hours in sexual offender assessment and evaluation)
sexual offender treatment	640 hours	(no more than 300 hours of case staffing or crisis management may be counted)
Total:	1500 hours	

3. On another sheet, please provide the name(s), address(s) and telephone number(s) of the supervising agency and/or agency for which you worked. Describe your duties with the agency. Please also describe how the required hours were aquired and include substantiating documentation.

Do you have at least 500 face-to-face hours in adult sexual offender evaluation?	☐ Yes	☐ No
Do you have some non-psychosexual treatment experience with adult sexual offenders?	☐ Yes	☐ No
Do you have at least 60 hours of sexual offender-specific specialized training?	☐ Yes	☐ No
Do you have a minimum total of 1500 hours of training and experience related to adult sexual offenders?	☐ Yes	☐ No

Associate/Supervised Certified Psychosexual Evaluator:

1. You must have completed a combination of direct clinical practice with adult sexual offenders and received specialized training for a minimum of 500 hours within the 3 years immediately preceding this application.
2. Of the 500 hours clinical practice and specialized training requirement:
   a. At least 100 hours in sexual offender evaluation experience;
   b. May include clinical practice hours in adult sexual offender treatment;
   c. A minimum of 60 hours or a maximum of 175 hours in sexual offender-specific specialized training;
      i. No more than 16 training hours may be attributed to the treatment of sexual abuse victims.
      ii. Must include a minimum of 30 hours in sexual offender assessment and evaluation.

Examples:		
Psychosexual evaluations	100 hours	
Specialized training	175 hours	(including at least 30 hours in sexual offender assessment and evaluation)
sexual offender treatment	225 hours	
Total:	500 hours	

Or:		
Psychosexual evaluations	200 hours	
Specialized training	60 hours	(including at least 30 hours in sexual offender assessment and evaluation)
sexual offender treatment	240 hours	
Total:	500 hours	

Associate / Supervised Certified Psychosexual Evaluator, cont.

3. On another sheet, please provide the name(s), address(s) and telephone number(s) of the supervising agency and/or agency for which you worked. Describe your duties with the agency. Please also describe how the required hours were aquired and include substantiating documentation.

Do you have at least 100 face-to-face hours in adult sexual offender evaluation?	☐ Yes	☐ No
Do you have some non-psychosexual treatment experience with adult sexual offenders?	☐ Yes	☐ No
Do you have at least 60 hours of sexual offender-specific specialized training?	☐ Yes	☐ No
Do you have a minimum total of 500 hours of training and experience related to adult sexual offenders?	☐ Yes	☐ No

PROFESSIONAL INFORMATION

1. Approximately how many sexual offender evaluations have you conducted in the indicated time frames?

Past 3 Years	Past 1 Year	
_____	_____	Convicted sexual offenders
_____	_____	Social services evaluations (typically alleged incest offenders)
_____	_____	Other (explain) _____
_____	_____	Evaluations prior to case disposition (e.g. a referral from a defense attorney)
_____	_____	TOTAL

2. Please identify the types of sexual offenders with whom you have worked:

_____ Adult	_____ Extra-Familial
_____ Juvenile	_____ Violent Offenders
_____ Intra-Familial	_____ Low Functioning (IQ under 75)
_____ Female	_____ Other (explain) _____

3. Have you ever been denied membership in, or terminated from a professional organization?

☐ Yes ☐ No (If yes, provide & attach a full explanation.)

4. Have you ever had a professional license, certification or registration revoked, suspended, or otherwise sanctioned; or have you ever surrendered such credential to avoid or in connection with action by such authority?

☐ Yes ☐ No (If yes, provide & attach a full explanation.)

5. Are you currently being investigated for or pending resolution of an alleged ethical standards violation by a professional licensing board?

☐ Yes ☐ No (If yes, provide & attach a full explanation.)

6. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect; or had prosecution or sentence deferred or suspended, in connection with:

☐ Yes ☐ No The use or distribution of controlled substances?

☐ Yes ☐ No Criminal sexual or violent behavior?

☐ Yes ☐ No Any other crime, other than minor traffic infractions? (Including DUI and reckless driving.)

(If yes to any of the above, provide & attach a full explanation.)

SPECIALIZED TRAINING AND TREATMENT

Specialized Training and Treatment Requirement:

At least 60 hours of specialized training and treatment within the preceeding 3 years is required for Senior/Approved or Associate/ Supervised level initial certification. Please refer to the combined professional experience/specialized training hour requirement explanation on page **3** of this application.

- Clinical supervision hours may not be used as "training."

Specialized training may be in a combination of areas such as:

- Assessment and evaluation of adult sexual offenders **(AE)**;
- Contemporary research regarding the etiology of sexually abusive behavior **(ESAB)**;
- Research-identified risk factors for the development and continuation of sexually abusive/offending behavior for adults **(RF)**;
- Contemporary research and practice in the areas of assessment, treatment, and management of adult sexual offenders **(ATM)**;
- Research-supported, sexual offender-specific risk assessment tools for adults **(RAT)**;
- Physiological assessment of deviant sexual arousal and/or interests **(PA)**;
- Treatment of sexual abuse victims (limited to 16 hours) **(SAV)**;
- Other – indicate how the training applies **(O)**.

Please list the specialized training courses, seminars, formal conferences, etc., which you have attended to demonstrate that you meet this requirement. ***Designate the relevant topic code (ESAB; RF; ATM; RAT; PA; SAV; O) for each training listed***.

Additionally, provide documentation verifying your attendance and completion (such as copies of programs or course certificates).

Seminar Name	Date	Location	Sponsor	Hours	Topic Code

Seminar Name	Date	Location	Sponsor	Hours	Topic Code
			Total Hours		

Please explain the applicability of any training coded as "**O**" below:

ASSURANCES AND RELEASE

I acknowledge and agree to the following:

I have read this entire application. Answered all question truthfully and completely and to the best of my knowledge, the documentation provided in support of my application is accurate.

I agree to adhere to the evaluation format as approved by the Idaho Sexual Offender Management Board (SOMB).

I have read and will comply with Idaho laws and rules, including the Idaho SOMB Standards and Guidelines governing Adult Sexual Offender Management Practices and agree to carry out the standards to the best of my ability related to the certification for which I am applying.

I give permission for the SOMB to investigate my background as it relates to statements contained in this application for certification. I understand that intentionally false or misleading statements or intentional omissions will result in the denial or revocation of certification. I further understand that the SOMB may require additional information from me prior to making a determination regarding my application.

I understand that the information contained in my SOMB certification application file may be shared with SOMB staff or other authorized representatives.

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, or federal), including professional licensing boards, to release upon the request of the SOMB or its authorized representatives any information files or records required by the SOMB in connection with processing this application. I understand that by signing this form I am authorizing the release of information about me that may otherwise be protected or confidential.

I further agree to hold the SOMB members and its staff or authorized representatives free from any civil liability for damages or complaints by reason of any action that is within the scope of the performance of their duties which they may take in connection with this application and/or the failure of the SOMB to issue certification.

Upon certification and as a condition of continued certification, I understand the SOMB members or its authorized representatives may contact or question, as necessary, any person, institution or organization during an investigation into any complaint made against me or as part of the quality assurance process.

_____ _____

Applicant Signature Date

Please PRINT your name below <u>exactly</u> as you wish it to appear on your certificate.

_____

PRINT

REFERENCES AND CONTACT INFORMATION

Please list the names, current addresses and phone numbers of (3) individuals who are familiar with your professional qualifications.

You are responsible for sending copies of the enclosed Letter of Reference form to the individuals you have listed below. They will be instructed to mail the completed forms directly to the SOMB.

1. Name:

   Position/Organization:

   Address:

   Telephone Number:

2. Name:

   Position/Organization:

   Address:

   Telephone Number:

3. Name:

   Position/Organization:

   Address:

   Telephone Number:

Optional: List the names, current addresses and phone numbers of (3) Idaho Dept. of Correction Community Corrections (Probation/Parole) or other law enforcement or Health and Welfare agency employees who are *not* listed as your references, but with whom you regularly work.

1. Name:

   Position:

   Address:

   Telephone Number:

2. Name:

   Position:

   Address:

   Telephone Number:

3. Name:

   Position:

   Address:

   Telephone Number:

LETTER OF REFERENCE FOR CERTIFIED PSYCHOSEXUAL EVALUATOR APPLICANT

(Applicant name) _____ has applied to be an Idaho Certified Psychosexual Evaluator.

The applicant has requested that you provide a statement regarding his/her professional and ethical qualifications. Your responses will not be shared with the applicant. Upon completion please mail or fax this letter of reference directly to the address/fax number listed below.

1. Your name and occupation: _____

2. You have known the applicant: professionally for _____ years; personally for _____ years.

3. How are you familiar with the applicant's work regarding evaluation of sexual offenders?

4. Do you believe the applicant demonstrates ethical integrity in professional and personal behavior?

   ☐ Yes ☐ No (If No, please attach an explanation.)

5. To the best of your knowledge, has the applicant ever been accused, investigated, and/or involved in unprofessional, illegal or unethical conduct?

   ☐ Yes ☐ No (If Yes, please attach an explanation.)

6. Please list the applicant's strengths and weaknesses regarding his/her work with convicted sexual offenders:

7. In your opinion, would you recommend this applicant for Psychosexual Evaluator Certification?

   ☐ I highly recommend ☐ I recommend

   ☐ I have reservations about recommending ☐ I strongly do not recommend

   (Please attach an explanation.)

I certify that to the best of my knowledge, the answers and statements provided above are true and complete.

Signature Date Telephone

Please return this reference to:

Sexual Offender Management Board
c/o IDOC Clinical Services Annex
3125 S. Shoshone St.
Boise, ID 83705
FAX (208) 954-8519

REQUEST FOR CONDITIONAL WAIVER

Applicants may apply for one time only conditional waiver only if they do not fully meet the professional experience qualifications and/or specialized training requirements.

Provisions:

1. Conditional waivers are limited to a period of two years, to afford the applicant time to attain the qualification requirements for the level of certification the applicant is seeking.

2. An applicant who is granted a conditional waiver may not represent himself/herself as a Certified Evaluator.

   a. An applicant who is granted a conditional waiver must indicate on the psychosexual evaluation signature line that he/she is an "**Approved Senior (or Associate) Psychosexual Evaluator by Waiver**."

   b. The psychosexual evaluator roster published by the SOMB will identify an evaluator who is granted a conditional waiver, and will indicate the date the waiver expires.

3. The applicant must have a training plan to achieve full qualification requirements for the level of certification that the applicant is seeking.

4. Documentation must be included with the evaluator's ***renewal*** application verifying his/her progress in attaining full qualification requirements for the level of certification the applicant is seeking.

5. If an applicant has not achieved the full qualification requirement for the level of certification originally sought during the two-year conditional waiver period, the waiver will be cancelled and the applicant will be placed in a less independent level of certification. Waivers will not be renewed.

I certify that I understand and agree to abide by the provisions for an approved evaluator conditional waiver.

Attached to this application is:

- A statement indicating why my request for conditional waiver should be considered; and
- A statement outlining my intended training plan to achieve full qualifications for the level of certification that I am seeking.

_____ _____

Applicant Signature Date

ATTACHMENTS

Have you attached the following? (**As applicable for level of certification**)

____ Copy of current Idaho professional license;

____ Documentation verifying current malpractice insurance;

____ Documentation qualifying professional experience;

____ Documentation verifying specialized education attendance;

____ Documentation verifying or explaining qualifications to conduct applicable psychological testing (see the Standards and Guidelines appendix for psychological testing qualifications);

____ A description of how you conduct a psychosexual evaluation, indicating the tests, techniques and/or instruments routinely used;

____ 2 redacted psychosexual evaluations (on adult clients) that you conducted within the past year;

____ Signed Assurances and Release form; and

____ Application processing fee – check or money order made payable to the Sexual Offender Management Board:
- $75 for Senior/Approved and Associate/Supervised certification levels;
- $50 for Provisional/Supervised certification level.

And if applicable,

____ Formal supervision agreement – applications for Associate and Provisional level providers will not be approved without pre-arranged supervision agreements;

____ Signed Application for Conditional Waiver form, with training plan outlining how you intend to meet applicable certification level requirements prior to certification renewal.

Please mail your application and attachments to:

SOMB Application
Attn: Accounts Receivable
Idaho Dept. of Correction
1299 N. Orchard St. Suite 110
Boise, ID 83706

Please direct questions to:

Sexual Offender Management Board
c/o IDOC Clinical Services Annex
3125 S. Shoshone St
Boise, ID 83705
(208) 954-8511