**INITIAL CERTIFICATION APPLICATION**
**INFORMATION AND INSTRUCTIONS**
**IDAHO SEXUAL OFFENDER**
**TREATMENT PROVIDER – ADULT CLIENTS**

Thank you for your interest in Idaho Sexual Offender Treatment Provider Certification.

Please note the following:

- Idaho Certified Treatment Providers must maintain at least masters-level professional licensure in a mental health field, or as a medical doctor in the state in which they provide services. Provisional/Supervised-level providers are required to be in the process of obtaining their masters-level professional licensure if they aren't already licensed.
- The application processing fee for initial certification is $75 for Senior/Approved and Associate/Supervised level treatment providers. The application processing fee for Provisional/Supervised level providers is $50. Treatment providers who also wish to be certified as psychosexual evaluators 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.
- Certification approval applies to work with either adult clients or juvenile clients. Separate certification applications must be submitted for each population served.

- An attachment checklist can be found on the last page of the application to assist you in ensuring that required documentation is included.
- Information about provider qualifications and treatment standards is located in the SOMB's Standards and Guidelines for Adult Sexual Offender Management practices 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 that district.

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
1299 N ORCHARD ST. STE 110 ♦ BOISE, ID ♦ 83706
TEL: (208) 658-2002 ♦ FAX: (208) 287-3322

| FOR OFFICE USE ONLY | |
|---|---|
| DATE RECEIVED | ISSUANCE DATE |
| CERTIFICATE # | |

# IDAHO SEXUAL OFFENDER TREATMENT PROVIDER
# INITIAL CERTIFICATION APPLICATION – ADULT SERVICES

**Check All That Apply:**

- ☐ Senior/Approved Treatment Provider
- ☐ Associate/Supervised Treatment Provider
- ☐ Provisional/Supervised Treatment Provider
- ☐ Reciprocity Consideration
- ☐ 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 |
|---|---|---|
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| Business Name & Address 1 | Telephone | |
|---|---|---|
| | | |
| City | State | ZIP |
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| Mailing Address if Different From Above | Alternate Telephone | |
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| City | State | ZIP |
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| Business Name & Address 2 | Telephone | |
| | | |
| City | State | ZIP |
| | | |

| Gender ☐ Female ☐ Male | Date of Birth | E-mail Address |
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List Any Other Names You Have Been Known Under

Which Judicial Districts Would You Like to be Listed Under on the Sexual Offender Treatment Provider 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 certificates or license is current.

| State/ Jurisdiction | Profession | Grantor | Certificate or License | | Permanent, Temporary or Other: explain | Currently Valid: explain if not valid. |
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| State/ Jurisdiction | Profession | Grantor | Certificate or License | | Permanent, Temporary or Other: explain | Currently Valid : explain if not valid. |
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## EDUCATION INFORMATION

Highest degree earned_____ Year_____
In the spaces below, provide a chronological listing of your post-secondary 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 | | | | |
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## 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 |
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## PROFESSIONAL EXPERIENCE/SPECIALIZED TRAINING REQUIREMENT

**Senior/Approved Sexual Offender Treatment Provider:**

1. You must have completed a combination of direct clinical practice with adult sexual offenders and 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 treatment experience;
   b. May include clinical practice hours in adult sexual offender assessment and evaluation;
   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.

| Examples: | |
|---|---|
| Sexual offender treatment | 700 hours |
| Specialized training | 375 hours |
| Psychosexual evaluations | 425 hours |
| Total: | 1500 hours |

| Or: | |
|---|---|
| Sexual offender treatment | 1440 hours |
| Specialized training | 60 hours |
| 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 treatment? | ☐ 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 Sexual Offender Treatment Provider:**

1. You must have completed a combination of direct clinical practice with adult sexual offenders and specialized training for a minimum of 500 hours within the 3 years immediately preceding this application.
   a. Clinical practice hours must include:
      i. A minimum of 100 hours engaged in direct observation of a Senior/Approved Sexual Offender Treatment Provider conducting specialized sexual offender treatment; and
      ii. A minimum of 100 hours engaged in co-facilitation of sexual offender treatment under the supervision of a Senior/Approved Sexual Offender Treatment Provider.
2. Of the 500 hour clinical practice and specialized training requirement:
   a. 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.
   b. May include clinical practice hours in adult sexual offender assessment and evaluation.

| Examples: | |
|---|---|
| Sexual offender treatment | 225 hours |
| Specialized training | 175 hours |
| Psychosexual evaluations | 100 hours |
| Total: | 500 hours |

| Or: | |
|---|---|
| Sexual offender treatment | 440 hours |
| Specialized training | 60 hours |
| Total: | 500 hours |

## PROFESSIONAL EXPERIENCE/SPECIALIZED TRAINING REQUIREMENT

**Associate/Supervised Sexual Offender Treatment Provider, 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 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 |
| Do you have a minimum of 100 hours experience directly observing a Senior/Approved sexual Offender Treatment Provider conducting specialized sexual offender treatment services? | ☐ Yes | ☐ No |
| Do you have a minimum of 100 hours experience co-facilitating sexual offender treatment services under the supervision of a Senior/Approved Sexual Offender Treatment Provider? | ☐ Yes | ☐ No |

## PROFESSIONAL INFORMATION

1. 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) _____

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

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

3. 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.)

4. 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.)

5. 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 & TREATMENT

**Specialized Training Requirement:**

At least 60 hours of specialized training within the preceeding 3 years is required for initial Senior/Approved or Associate/Supervised level 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 "Specialized training hours."

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 |
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| Seminar Name | Date | Location | Sponsor | Hours | Topic Code |
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| | | | **Total Hours** | | |

| Explain the applicability of any training coded as "**O**" below: |
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## 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 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 Idaho Sexual Offender Management Board (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 may 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 SEXUAL OFFENDER TREATMENT PROVIDER APPLICANT

(Applicant name) _____ has applied to be an Idaho Certified Sexual Offender Treatment Provider.

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 clinical treatment for 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 sexual Offender Treatment Provider 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 Idaho Dept. of Correction
1299 N Orchard St. Ste 110
Boise, ID 83706
FAX (208) 287-3322

## REQUEST FOR CONDITIONAL WAIVER

***Applicants may apply for a 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 Sexual Offender Treatment Provider.

   a. An applicant who is granted a conditional waiver shall represent himself/herself as an "**Approved Senior (or Associate) Sexual Offender Treatment Provider by Waiver**."

   b. The sexual offender treatment provider roster published by the SOMB will identify a sexual offender treatment provider 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 sexual offender treatment provider'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.

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I certify that I understand and agree to abide by the provisions for an approved sexual offender treatment provider 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 professional license (licensure in Idaho is not required to be certified as an Idaho sexual Offender Treatment Provider, however, you must maintain a current license in a clinical practice field such as psychiatry, psychology, counseling or social work, etc. in your state of residence);

____ Documentation verifying current malpractice insurance;

____ Documentation qualifying professional experience;

____ Documentation verifying specialized education attendance;

____ Documentation related to your treatment program curriculum:

- Program narrative describing your treatment theory/model
- Treatment acceptance criteria
- Templates of treatment plans, treatment contracts and agreements
- Assessment tools utilized to inform treatment planning and to gauge treatment progress
- Data collected to assess program impact and effectiveness
- Program modality (e.g. individual, group, family, etc.)
- Treatment program rules and expectations
- Description of how treatment plans are developed and modified
- Outline of modules, exercises and activities

____ Copies of the following documents that were developed on separate adult clients within the year preceding this application:

- 2 redacted treatment plans
- 2 redacted treatment summaries
- 2 redacted treatment progress reports

____ 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 – <u>applications for Associate and Provisional level providers will not be approved without pre-arranged supervision agreements</u>;

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

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**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 Idaho Dept. of Correction
1299 N. Orchard St. Ste 110
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