

**APPLICATION FOR APPROVED SEX OFFENDER TREATMENT PROVIDER PROTOCOL (STP)**

**Please Type or Print Clearly** – Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

**1. DEMOGRAPHIC INFORMATION**

NAME LAST FIRST MIDDLE INITIAL

ADDRESS

CITY STATE ZIP COUNTY

TELEPHONE SOCIAL SECURITY NUMBER

GENDER BIRTHDATE (MO/DAY/YR) PLACE OF BIRTH  
 Female  Male

Have you ever been known under any other names?  Yes  No

If yes, list full name(s)

**2. OREGON STATE LICENSURE/CERTIFICATION/REGISTRATION INFORMATION**

PROFESSION ISSUE DATE LICENSE/CERT/REG. NO

**3. PREVIOUS LICENSURE OR CERTIFICATION**

List all states where certificate(s) or licenses are or were held. (Previous credential to include license, certification or registration such as certified or associate sex offender therapist.) Specifically list certificate(s) or licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if certificate(s) or license is current.

STATE	PROFESSION	CERTIFICATE OR LICENSE		PERMANENT OR TEMPORARY	LICENSE RECEIVED BY		CURRENTLY IN FORCE
		YR ISSUED	NUMBER		EXAMINATION	OTHER	

**4. EDUCATION**

Highest degree earned \_\_\_\_\_ Year \_\_\_\_\_

In the spaces below, provide a chronological listing of your educational preparation and post-graduate training. (Attach an additional sheet of 8 1/2 x 11 inch paper if needed.)

FULL NAME, CITY & STATE SCHOOLS ATTENDED	ATTENDANCE		DATE GRADUATED	DEGREE EARNED	MAJOR AREA OF STUDY	SEMESTER/QTR HOURS EARNED
	FROM	THROUGH				

**5. PERSONAL DATA**

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.

“**Medical Condition**” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

- 1a. If you answered “yes” to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).
- 1b. If you answered “yes” to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.

“**Currently**” means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.

“**Chemical substances**” includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or frotteurism?

4. Are you currently engaged in the illegal use of controlled substances?

“**Currently**” means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.

“**Illegal use of controlled substances**” means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care provider.

**Note: If you must answer “yes” to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.**

5. Have you ever had police contact or been alleged to have committed any of the following?

a. the use or distribution of controlled substances or illegal drugs?

b. a charge of a sex offense?

c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| <b>6.</b> 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:  |                          |                          |
| a. the use or distribution of controlled substances or illegal drugs?   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. a charge of a sex offense?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>7.</b> Have you ever been found in any civil, administrative or criminal proceeding to have:   |                          |                          |
| a. possessed, used, prescribed for use, or distributed controlled substances or illegal drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or illegal drugs, violated any drug law, or prescribed controlled substances for yourself?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| b. committed any act involving moral turpitude, dishonesty or corruption?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. violated any state or federal law or rule regulating the practice of a health care professional?   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>8.</b> Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, explain and provide copies of all judgments, decisions, and agreements.   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>9.</b> Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority. | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>10.</b> Have you ever suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?   | <input type="checkbox"/> | <input type="checkbox"/> |

**6. PROFESSIONAL EXPERIENCE**

In chronological order, list all professional experience. (Exclude activities listed under other sections.) Attach an additional sheet of 8 1/2 X 11 paper if needed.

INDICATE NATURE OF EXPERIENCE OR PRACTICE AND LOCATION	INCLUSIVE DATES OF EXPERIENCE	
	BEGINNING DATE	ENDING DATE

To qualify as an approved provider, you must qualify as a certified or associate sex offender therapist under the Oregon Health Licensing Board.

Describe how your required supervision hours were acquired and calculated: Please calculate your face-to-face treatment and evaluation hours for which you had primary responsibility separately to show how you established your 2000 hours (example: 6 clients per week 1 hour each totaling 6 hours per week times how many years practicing). Attach additional sheet of 8 ½ x 11 paper if necessary.

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List the documentation you have to substantiate your hours; e.g., billing, affidavit of supervision, agency records:

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**7. SEX OFFENDER SPECIFIC THERAPIST APPLICANTS**

Please provide the name, address and telephone number of your supervisor who will provide supervision when working with Yamhill County sex offender clients.

Provide a copy of the contract entered into by yourself and supervisor.

Supervisor's Name \_\_\_\_\_

Work Telephone \_\_\_\_\_ Home Telephone \_\_\_\_\_

Supervisor's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_



## REQUEST FOR PROFESSIONAL TRAINING AND REFERENCES

Applicant's Name \_\_\_\_\_

**PROFESSIONAL TRAINING (Obtained within the last two years)**

List hours of training (courses, seminars, formal conferences, etc.) directly related to the treatment and evaluation of sex offenders or victims of abuse, copies of program or course certificates is acceptable.

SEMINAR NAME	DATE	LOCATION	SPONSOR	HOURS

**SOURCE VERIFICATION**

List a professional reference(s) that can verify your experience requirements.

NAME	ADDRESS	TELEPHONE