APPLICATION FOR CERTIFICATION

SEX OFFENDER TREATMENT PROVIDER

INDEPENDENT PROVIDER LEVEL

California Sex Offender Management Board

1515 S Street, 212 - North, Sacramento, CA 95811

Website: www.casomb.org

Contact Information for Inquiries Regarding the Certification Process is Available at: http://www.casomb.org

Who should complete this application:

Every individual who wishes to provide services as a Certified Independent Provider to convicted sex offenders pursuant to Penal Code Section 290.09 and Sections 1203.067 and 3008 must complete this application. Providers must demonstrate that they meet the qualifications and comply with standards of practice contained in *Sex Offender Treatment Provider Certification Requirements,* published in June, 2011, by the California Sex Offender Management Board (CASOMB). This application should only be completed by individuals, not partnerships, groups or programs. Note that each person providing the designated services must be certified as an individual AND may only provide such services within the setting of a CASOMB Certified Program. Program certification is a separate process. Refer to the information provided at http://www.casomb.org/certification.htm.

How to complete this application:

- The applicant should **read and understand** the *Certification Requirements* before completing this application. This document is available at: http://www.casomb.org/certification.htm.

- Within the body of this application, providers will be asked to report their training, education, experience, and clinical licensure. Applicants may wish to compile the relevant records and materials in advance. Submission of the verifying documentation is not required as a part of the initial application but the documents substantiating the claimed experience and training may be requested by CASOMB at any time, whether for cause or as part of a random audit.

- When complete, the application should be mailed to the **CASOMB Certification Unit, 1515 S Street, 212 – North, Sacramento, CA 95811**. The applicant should be sure to save a copy of the completed application and attached documentation.

Additional Responsibilities if placed on the Certified Provider List:

- All Certified Providers (Independent, Associate, Apprentice) must work for a Certified Program.

- It is the responsibility of each certified provider to notify CASOMB, in writing, of any changes to the provider's name, address, telephone number, email address, license status, affiliated Certified Program or other key information.

APPLICATION CHECKLIST

All of the following steps must be taken to apply to become a Certified Independent Provider. This checklist must be completed, signed and turned in with the application. Your application will be delayed a minimum of 30 days if all of the required documents are not submitted correctly.

☐ **Complete and submit the Application Form.**
Do not omit any of the parts of the Form. Sign the Form in the required location on the Attestation page.

☐ **Submit the Application Fee - $180**
Include a personal check, money order or cashier's check payable to "CDCR" with the application materials submitted. This fee is nonrefundable.

☐ **Submit a copy of ***one*** of the following:**

- Driver's License
- State ID card
- Passport
- Military ID card

Did you complete the following portions of the application:

☐ Applicant Information

☐ Education

☐ Licensure

☐ Personal Data

☐ Experience

☐ Training

☐ Attestation

☐ **Complete the Live Scan Fingerprinting Procedure**

To complete the Live Scan fingerprinting procedure, each applicant will need to:

1. Complete the required portions of the Request for Live Scan Service form (BCII 8016) provided on the CASOMB website and **print three (3) copies** of the form to be taken with you to the Live Scan vendor. The agency information included on this form is unique to the CASOMB Certification Program and failure to use the form provided will result in delay of certification.

2. Find a conveniently located Live Scan provider by searching the list of approved sites found at http://ag.ca.gov/fingerprints/publications/contact.php. *Please be sure to go to a provider who will accept direct payment from the customer. Do not go to a provider who only does "BILLING NUMBER REQUIRED" scans*.

3. Bring a *valid* form of picture identification along with the fingerprint form of this application to the Live Scan provider.

4. Pay the Live Scan provider the fee for having the scan done. Fees charged at different locations may vary. The fee currently charged at each location is indicated on the above website.

5. Have fingerprints scanned. Once the fingerprints have been taken, nothing more need be done. The prints will be sent to the California Department of Justice for processing. The cost of processing is included as part of the $180 application fee. Any applicant who does not receive background clearance from the Department of Justice will be notified of the outcome by CASOMB. Others may assume that the needed clearance has been obtained.

Signature of Applicant:_____ **DATE:** _____

CASOMB APPLICATION FORM

APPLICATION TO BE A CERTIFIED INDEPENDENT PROVIDER

New Applicant ☐ Upgrade ☐

COMPLETE ALL PARTS OF THIS FORM. Contact the California Sex Offender Management Board (Contact information at www.CASOMB.org) if there are any questions. Incomplete applications will not be processed or returned. Use "N/A" to indicate information that is not applicable. This information will be used to document and evaluate applicant qualifications. Applicants will be informed via email if their application is unable to be completely processed.

Applicant Information

LAST NAME: **FIRST NAME:** **MIDDLE INITIAL:**

PHYSICAL ADDRESS:

CITY: **STATE:** **ZIP CODE:**

MAILING ADDRESS (If different):

CITY: **STATE:** **ZIP CODE:**

TELEPHONE NUMBER:

EMAIL: **SOCIAL SECURITY NUMBER: - -**

GENDER: MALE ☐ FEMALE ☐

BIRTH DATE:

Have you ever been known under any other name (s)? YES ☐ NO ☐

If yes, please list the name(s): _____

Please list languages, other than English, which you speak fluently and in which you can demonstrate clinical proficiency:

Initial Certification Requirements – Independent Provider Level

1. EDUCATION:

Please list the highest level of education that you have completed.

UNIVERSITY OR COLLEGE – NAME AND LOCATION, BUSINESS, CORRESPONDENCE, TRADE OR SERVICE SCHOOL	COURSE OF STUDY	DIPLOMA, DEGREE, OR CERTIFICATE OBTAINED	DATE COMPLETED

2. LICENSURE:

Mental Health Licensure/Certification/Registration Information

List any certification(s), license(s), or registrations currently held which are required to meet the certification criteria and which support this certification application.

PROFESSION	ISSUE DATE	STATE	LICENSE/CERTIFICATION/REGISTRATION NUMBER

PERSONAL DATA QUESTIONS

If the application includes a YES response to any of the personal data questions, the applicant must submit additional supporting documentation and a letter of explanation for that question, as indicated on the application. A "Yes" response will not necessarily result in application denial; however, failure to honestly respond could be grounds to deny an application

	YES / NO
1. Has any state licensing board refused to issue, refused to renew or denied you a license to practice?	☐ / ☐
2. Have you ever had any disciplinary or adverse action imposed against any professional license or certification, or were you ever denied a professional license or certification, or have you entered into any consent agreement, stipulated order or settlement with any regulatory board or certification agency; or have you ever been notified of any complaints or investigations related to any license or certification?	☐ / ☐
3. Have you ever been arrested, charged with, entered a plea of guilty, no contest, convicted of or been sentenced for any criminal offense either misdemeanor or felony, including driving under the influence, in any state? (The fact that a conviction has been pardoned, expunged, dismissed or that your civil rights have been restored does not mean that you answer this question "NO"; you would answer "YES" and give details on the charge.)	☐ / ☐
4. Are you aware of any current, proposed, impending or threatened civil or criminal action against you? This includes whether or not a claim, charge or filing was actually made with court.	☐ / ☐
5. Do you currently, or have you had within the past five (5) years, any physical, mental, or emotional condition which impaired, or does impair your ability to practice your profession safely and competently?	☐ / ☐
6. Do you currently have, or have you had within the past five (5) years, a dependency on the use of alcohol or drugs which impaired, or does impair, your ability to practice your health care profession safely and competently?	☐ / ☐
7. Within the past five (5) years, have you entered into a diversion program for evaluation, treatment, or monitoring for substance abuse or dependency, or for correction of communication or boundary issues, in lieu of or as a condition of resolving a matter before a health care program or facility, regulatory or licensing board, or criminal or civil court; or have you been notified that such action is pending or proposed?	☐ / ☐

3. EXPERIENCE: Includes direct face-to-face or other qualifying therapy with sex offenders

Experience Reporting Form

EXPERIENCE PROVIDING SERVICES TO SEX OFFENDERS – 500 Hours of Clinical Experience Within The Last Two Years Are Required Providing Services to Sex Offenders. At Least 350 of these Hours Are Required To Be Direct Face-To-Face Therapy With Sex Offenders or Direct Supervision provided to Sex Offender Therapists who are delivering such services.

List professional experience providing direct treatment services, supervision or indirect services, listing the most recent first. Complete all parts of this form. Attach additional pages as needed. Hours of experience listed must be able to be verified upon CASOMB request. It is not necessary to list all of one's experience, but enough hours to meet the stated requirements must be included.

EMPLOYER:	**PHONE:**	
EMPLOYER STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
DATES OF EMPLOYMENT FROM:	**TO:**	
JOB TITLE:	**NAME OF SUPERVISOR (If any):**	
BRIEFLY DESCRIBE SETTING (350 characters or less):*		
BRIEFLY DESCRIBE DUTIES (350 characters or less):		
BRIEFLY DESCRIBE CLIENT POPULATION (350 characters or less):		
NUMBER OF DIRECT FACE-TO-FACE CLIENT HOURS OR SUPERVISION HOURS PROVIDED:	**OTHER QUALIFYING HOURS** (OTHER THAN DIRECT FACE-TO-FACE OR SUPERVISING**):**	

EMPLOYER:	**PHONE:**	
EMPLOYER STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
DATES OF EMPLOYMENT FROM:	**TO:**	
JOB TITLE:	**NAME OF SUPERVISOR (If any):**	
BRIEFLY DESCRIBE SETTING (350 characters or less):*		
BRIEFLY DESCRIBE DUTIES (350 characters or less):		
BRIEFLY DESCRIBE CLIENT POPULATION (350 characters or less):		
NUMBER OF DIRECT FACE-TO-FACE CLIENT HOURS OR SUPERVISION HOURS PROVIDED:	**OTHER QUALIFYING HOURS** (OTHER THAN DIRECT FACE-TO-FACE OR SUPERVISING**):**	

EMPLOYER:	**PHONE:**	
EMPLOYER STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
DATES OF EMPLOYMENT FROM:	**TO:**	
JOB TITLE:	**NAME OF SUPERVISOR (If any):**	
BRIEFLY DESCRIBE SETTING (350 characters or less):*		
BRIEFLY DESCRIBE DUTIES (350 characters or less):		
BRIEFLY DESCRIBE CLIENT POPULATION (350 characters or less):		
NUMBER OF DIRECT FACE-TO-FACE CLIENT HOURS OR SUPERVISION HOURS PROVIDED:	**OTHER QUALIFYING HOURS** (OTHER THAN DIRECT FACE-TO-FACE OR SUPERVISING**):**	

EMPLOYER:	**PHONE:**	
EMPLOYER STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
DATES OF EMPLOYMENT FROM:	**TO:**	
JOB TITLE:	**NAME OF SUPERVISOR (If any):**	
BRIEFLY DESCRIBE SETTING (350 characters or less):*		
BRIEFLY DESCRIBE DUTIES (350 characters or less):		
BRIEFLY DESCRIBE CLIENT POPULATION (350 characters or less):		
NUMBER OF DIRECT FACE-TO-FACE CLIENT HOURS OR SUPERVISION HOURS PROVIDED:	**OTHER QUALIFYING HOURS** (OTHER THAN DIRECT FACE-TO-FACE OR SUPERVISING**):**	

*E.G. Large multidisciplinary public agency; small private practice; residential program, jail; etc.

Total hours of experience providing direct face-to-face services to sex offenders or supervising such services:	_____ **HOURS**	Total of other services to sex offenders:	_____ **HOURS**	Total Service Hours	_____ **HOURS**

4. TRAINING:

Formal Training Reporting Form - Part I: Core Topics

Formal Training (Core Topics) – Minimum of 30 documented training hours within the **last two years** are required, 20 hours of which must be in Core Topics. (Note that it is completely acceptable to have more than 20 hours of training in Core Topics and that all 30 of the required formal training hours may be in Core Topics.)

List the Core Topic Training and Educational experiences which establish applicant's qualification. At least 20 hours of training must be listed. Up to 30 hours or more may be listed.

ACTIVITY/EVENT	DATE	TRAINING ORGANIZATION	HOURS
		Total Core Topic Hours:	

Formal Training Reporting Form - Part II: Adjunct Topics

Formal Training (Adjunct Topics) – Maximum of 10 hours of Adjunct Topics may be included towards completion of 30 hours within last two years. (Adjunct topics are not required if the total hours in core topics fulfill the entire 30 hour requirement.)

List the Adjunct Topic Training and Educational experiences which establish applicant's qualification. No more than 10 hours of Adjunct Topic training may be included in the 30 hour training total.

ACTIVITY/EVENT	DATE	TRAINING ORGANIZATION	HOURS
		Total Adjunct Topic Hours:	

TOTALS:

Core Topic Hours:	_____ **HOURS**	Adjunct Topic Hours:	_____ **HOURS**	**Total Training Hours:**	_____ **HOURS**

5. **SUPERVISION:** There are no supervision requirements for applicants at the Independent Provider level

Applicant's Attestation

I, _____, certify that I am the person described and identified in this application.

I have read and will abide by the *Sex Offender Treatment Provider Certification Requirements: Independent Provider Level*. I have answered all questions in this application truthfully and completely, and am able, upon request, to provide the documentation in support of my application information.

I understand that the California Sex Offender Management Board may require additional information from me prior to making a determination regarding my application, and may independently validate any information attested to in this application.

I affirm that I will keep the California Sex Offender Management Board informed of any change to my licensure status and any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my certification as a Certified Provider by the California Sex Offender Management Board; and will be reported to the California Department of Consumer Affairs licensing board for appropriate review and possible action upon my license. Any person who knowingly provides false information in connection with an application for certification as a sex offender management professional is subject to a civil penalty of up to $1,500, in addition to any other remedy available to the CASOMB, and would allow any public prosecutor to bring an action for a civil penalty in the name of the people of the State of California.

By signing my name in the space below, I certify under penalty of law that the above information is true and correct.

Number of Training Hours (Core Topics)	
Number of Training Hours (Adjunct Topics)	
Total Number of Training Hours	

Number of Direct Experience Hours	
Number of Other Experience Hours	
Total Number of Experience Hours	

Signature of Applicant: _____ **Date:** _____