



Application for Certified Sex Offender Treatment Provider (CSOTP)

Date: _____

Name (as it appears on your license): _____

Mailing Address: _____

City/State/Zip/Country: _____

Phone: _____

Email Address: _____

I attest to the following (please initial each):

____ I am a State or Nationally licensed professional (or equivalent if practicing outside of the United States) as outlined in Criterion 1.1 of the Certification Standards

____ My professional license is current and in good standing as outlined in Criterion 1.2 of the Certification Standards

____ I have completed the required 24 education clock hours training as outlined in Criterion 2.0 of the Certification Standards

____ I have, over the course of my career, completed a minimum of 2,000 clinical hours under supervision, with 200 of those hours specific to the evaluation and treatment of sex offender clients as outlined in Criterion 3.0 of the Certification Standards

I verify that this application is complete, accurate, and that the information provided and attested to is factual and true. I understand that if any of the information provided and attested to is false or found to be false, my certification will be denied and/or revoked, and my licensing board may be contacted.

I understand that information submitted with this application may be verified for accuracy by Evergreen Certifications. I also agree to contact Evergreen Certifications in the event I no longer meet the requirements to be a Certified.

Signed: _____ Date: _____