



Sex Offender Treatment Provider Credentialing
 P.O. Box 47877
 Olympia, WA 98504-7877
 360-236-4700

Sex Offender Treatment Provider (SOTP) Supervised Experience Completion Verification

1. Applicant		
Name First	Middle	Last
Birth date (mm/dd/yyyy)	Affiliate Number	
Address		
City	State	Zip Code
2. Supervisor (Provider)		
Supervisor Name		Phone (enter digit #)
Credential Number	Type of Credential(s)	First Issue Date
Address		
City	State	Zip Code
3. Supervised Experience (WAC 246-930-075)		
<p>Applicants must have a minimum of 2000 hours; at least 250 hours of treatment experience and 250 hours of evaluation experience. These hours must be verified by the provider with whom the affiliate has a signed and approved contract on file with the Department of Health. Please complete the actual months under your supervision</p> <p>Dates applicant was supervised: from _____ to _____</p> <p>Please complete the actual hours under your supervision.</p>		
Supervision	Total Hours	
Evaluation Experience (250 hours required).		
Estimate of evaluation hours counted other than face to face with a client.		
Treatment Experience (250 hours required).		
Estimate of treatment hours counted maintaining collateral contacts and written case/progress notes.		
Total number of supervised experience hours (2000 hours required).		
Supervisor		
<p>I certify the above information is, to the best of my knowledge, accurate and complete. I understand the department may request additional information, if it is needed, to evaluate the application of the individual named on this document. I also attest I have maintained an active SOTP and underlying credential during this time.</p>		
Signature _____		Date _____
<p>Return this form to the address listed above. mm/dd/yyyy</p>		