Washington State Department of Health
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)

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

Dates applicant was supervised: from _____ to _____

Please complete the actual hours under your supervision.

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

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.

Signature _____ Date _____
mm/dd/yyyy

Return this form to the address listed above.