



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

## Sex Offender Treatment Provider (SOTP) Supervision Contract

<b>1. Affiliate Applicant</b>			
Name	First	Middle	Last
Birth date (mm/dd/yyyy)		Underlying Credential Number	
Address			
City		State	Zip Code
<b>2. Supervisor (Provider)</b>			
Supervisor Name		Phone (enter digit #)	
SOTP Credential Number		Underlying Credential Number	
Address			
City		State	Zip Code
<p><b>WAC 246-930-075 Supervision of affiliates.</b> Supervision of affiliates requires the provider take full ethical and legal responsibility for the quality of work of the affiliate. Supervision of affiliates shall involve regular, direct and face-to-face supervision.</p> <p>This supervision contract must be submitted to the department for approval and shall include: Please attach documentation addressing these items.</p> <ul style="list-style-type: none"> <li>• Supervised areas of professional activity.</li> <li>• Amount of supervision time and the frequency of supervisory meetings. This information may be presented as a ratio of supervisory time to clinical work conducted by the affiliate.</li> <li>• Supervisory fees and business arrangements.</li> <li>• Nature of the supervisory relationship and the anticipated process of supervision.</li> <li>• Selection and review of clinical cases.</li> <li>• Methodology for record keeping, evaluation of the affiliate and feedback.</li> <li>• How the affiliate will be represented to the public and the parties.</li> </ul> <p><b>Provider:</b></p> <ul style="list-style-type: none"> <li>• Avoid presenting as having qualifications in areas he or she does not have them.</li> <li>• Provide sufficient training and supervision to the affiliate to assure the health and safety of the client and community.</li> <li>• Have expertise and knowledge to directly supervise affiliate work.</li> </ul>			

- Assure the affiliate being supervised has sufficient and appropriate education, background and preparation for the work he or she will be doing. Cosign all written reports and correspondence prepared by the affiliate.
- Do not undertake a contract that exceeds the provider's ability to comply with the supervision standards.
- Assure the affiliate is prepared to conduct professional work. Assure adequate supervision of the affiliate. The provider shall meet face-to-face with the affiliate a minimum of one hour for every ten hours of supervised professional work. Supervision meetings occur at least every other week.
- Supervise no more than two affiliates.
- All work conducted by the affiliate is the responsibility of the provider. The provider shall have authority to direct the practice of the affiliate.
- It is the provider's responsibility to correct problems or end the supervision contract if the affiliate's work does not protect the interests of the clients and community. If the provider ends the contract, he or she must notify the department in writing within thirty days of ending the contract. A provider may only change or adjust a supervision contract after receiving written approval from the department.
- Supervision is a power relationship. The provider must not use his or her position to take advantage of the affiliate.
- The provider shall ensure the affiliate has completed at least one thousand hours of supervised evaluation and treatment experience before the affiliate is authorized to evaluate and treat Level III sex offenders. The provider will submit to the department documentation the affiliate has completed a minimum of one thousand hours within thirty days of completion of the experience.

**Affiliate:**

- Represent him or herself as an affiliate only when performing clinical work supervised by the contracted provider.
- Maintain full documentation of the work done and supervision provided.

I certify the information included in this contract is accurate, and I have read and understand the requirements in [WAC 246-930-075](#) Supervision of affiliates.

Supervisor name (print) \_\_\_\_\_

Supervisor signature \_\_\_\_\_ Date \_\_\_\_\_  
mm/dd/yyyy

Affiliate applicant name (print) \_\_\_\_\_

Affiliate applicant signature \_\_\_\_\_ Date \_\_\_\_\_  
mm/dd/yyyy

**Please send the completed contract to the address above.**