

**Colorado Sex Offender
Management Board (SOMB)**

**APPLICATION 1
First Application
for Associate Level**

**for Placement on the
Adult and/or Juvenile Provider List**

POLYGRAPH EXAMINER



Sex Offender
Management Board

**Colorado Department of Public Safety
Division of Criminal Justice
Office of the Sex Offender Management Board
700 Kipling Street, Suite 3000, Denver, CO 80215**

<https://www.colorado.gov/dcj>

Telephone: (303) 239-4526 or 4199 | Fax: (303).239.4491



What Application Should I Be Using?

Application 1– First Application for Associate Level Polygraph

This application is used the first time an individual is applying to become an SOMB approved provider and will initiate the first year on the approved provider list. Application 1 is also used when a currently approved provider is applying to add an additional status to their listing (e.g. adding the DD/ID Specialty).

Application 2 - Initial Three-Year Associate and/or Change of Status Application

This application is used when a provider has completed the Application for New Providers, completed an initial 12-month listing and is now applying to be listed at the Associate or Full Operating Level for the next three (3) years.

Application 2 is also used when an approved provider is applying to move from Associate Level to Full Operating Level status.

Application 3 - Renewal of Current Listing as Associate Level, or Full Operating Level

This application is used when a currently approved provider has completed the Initial Three-Year Application (and the accompanying three (3) year listing) and is renewing their current status for the next three (3) year renewal period.

Who Should Complete this Application?

Individuals who wish to apply for Associate Level on the Sex Offender Management Board's approved provider list(s) shall submit this application to the Board pursuant to:

1. Section 4.000 of the *Standards and Guidelines*. They may be accessed via the following link: <https://www.colorado.gov/pacific/dcj/somb-standards-bulletins>.
2. The Competency-Based Provider Approval Model Summary may be accessed via the following link: <https://cdpsdocs.state.co.us/SOMB/APPLICATION/SOMBCompetencyAssessmentSummary.pdf>.

Please note: This listing is only valid for twelve (12) months. Any provider wishing to **add** onto their current status **shall** provide Application 1 (e.g. a treatment provider working towards becoming an evaluator, etc.). You will receive a letter from the Sex Offender Management Board staff indicating that your paperwork has been processed, and your name will subsequently be published on the provider list on the Sex Offender Management Board website. If you have more than one supervisor, please fill out a box for each. Please note, applicants shall apply as individuals, not partnerships or programs.

Treatment Providers/Evaluators should not submit this form.

Please see Provider applications via the following link:

<https://www.colorado.gov/pacific/dcj/somb-provider-applications#>

How to Complete this Application

- **Please read all of the application in its entirety.** It is updated and changed annually.
- The applicant should request assistance from his/her supervisor in completing this application.
- Within the body of this application, you will be asked to attest to your compliance with training and clinical experience according to very specific sections of the *Standards*. The applicant should first read and understand the *Standards* before completing this application. Within the body of this application, you will be asked to document your training; you may wish to compile these materials in advance.
- When complete, you should return a single-sided hard copy of the application with supplemental information to the address on the cover page, "Attention: SOMB". Save a copy of the completed application, including attached documents for your files.
- Additional copies of the *Standards* or the application materials may be obtained by contacting (303) 239-4526. *Standards* are also available at <http://dcj.somb.state.co.us/>
- Questions may be addressed to the Adult Standards Coordinator at (303) 239-4499 for questions pertaining to the adult portion of this application, and to the Juvenile Standards Coordinator at (303) 239-4197 for questions pertaining to the juvenile portion of this application.
- Standards compliance will be assessed over time through a periodic renewal process (every three years), a monitoring process, and a mechanism to receive and investigate complaints within the policies established for such complaints and via Standards Compliance Reviews according to the SOMB policy and procedure.

General Instructions

Your adherence to the instructions throughout the application will help ensure that your application is not returned to you by the Sex Offender Management Board staff or otherwise delayed.

1. Follow all instructions carefully.
2. Use the forms provided in this application.
3. Submit ONLY the information requested.
4. Submit the required information in the order requested.
5. Keep a copy of your completed application and attachments for your files.
6. **PLEASE DO NOT** use staples, paper clips, binders, sheet protectors or other materials because all applications are copied multiple times in their entirety during processing.
7. Please submit all materials on **SINGLE-SIDED COPIES.**

Please note, your application is not considered complete until the fingerprint process is completed. Please see page nine (9) for further information.

Compliance with the Standards will be assessed over time through a periodic renewal process (every three years), a standard compliance review process, and a mechanism to receive and investigate complaints within the policies established for such complaints.

Application for Placement on the Sex Offender Management Board's Provider List

Applicant Name: _____ Date: _____

Credentials (MA, LCSW, etc.): _____

Home Address: (Street, City, State and Zip Code): _____

Home Telephone Number: _____

Home Email: _____

Please note that the home address is considered CONFIDENTIAL and will only be used if the staff is unable to locate you through your employer. Employer or Business name, address, phone, fax, and email information is used for the approved provider list.

Agency: _____

Agency Address (Street, City, State and Zip Code): _____

Agency Telephone Number: _____

Business Email: _____

County of Primary Location: _____

Supervisor's Name: _____

Agency: _____

Agency Address (Street, City, State and Zip Code): _____

Agency Telephone #: _____

Email: _____

2nd Supervisor's Name (if applicable): _____

Agency: _____

Agency Address (Street, City, State and Zip Code): _____

Agency Telephone #: _____

Email: _____

Authorization for Release of Information

Adult and Juvenile Applicants

I, _____, authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to be on the Sex Offender Management Board's Provider List as an **Associate Level Polygraph Examiner**. I agree to give any further information that may be required in reference to my past record.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court association, or institutions having possession of any documents, records or other information pertaining to me, to furnish to the Sex Offender Management Board such information, including, but not limited to, documents and records, informal, pending or closed, or any other pertinent data and to permit the Sex Offender Management Board or any of its designated officers, committees, or staff to inspect and make copies of such documents, records and other information in connection with this application.

The foregoing authorization for release of information or records does not include consent for release of personal financial records, bank accounts, loans or other such personal information not related to my moral character, professional reputation, or fitness as a treatment provider and/or evaluator and/or polygraph examiner.

I hereby release, discharge and exonerate the Sex Offender Management Board, its agents and representatives, and any person furnishing such information from any and all liability of every nature and kind arising out of the furnishing of such information to other medical or professional societies or organizations, hospitals and hospital committees, and government agencies in the event that other such organizations and agencies present to the Sex Offender Management Board a release of authorization for release of information executed by me or a facsimile of such release or authority executed by me.

Signature of Applicant

Clearly Printed Applicant Name

Date

Associate Level Contract

I understand this contract is valid for 12 months. I will be able to submit my Application 2 for approval to the Board within **one year** from the date indicated on this contract.

I have read and understand the Competency-Based Treatment Provider, Evaluator Approval Model (Appendices of both the Adult and Juvenile Standards).

Please check all levels and/or specialties that you are applying for.

- | | |
|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Adult Associate Polygraph Examiner | <input type="checkbox"/> Juvenile Associate Level Polygraph Examiner |
| <input type="checkbox"/> Adult Developmental/Intellectual Disability Specialty | <input type="checkbox"/> Juvenile Developmental/Intellectual Disability Specialty |
-

For applicants who have a criminal history: Please enclose with this contract a written explanation of the charges, and verification of the disposition.

I understand that I must accumulate specialized training, and other requirements prescribed in Section 4.000 of the SOMB *Standards and Guidelines*. Supervision and training will be assessed through an individualized comprehensive supervision plan. The Application Review Committee may request a copy for review.

My supervisor and I are in agreement that supervision will be governed by the requirements prescribed in the SOMB Competency-Based Provider Approval Model.

Please note: Any supervision ***shall not*** be provided by a relative of the applicant.

I am enclosing:

- ☐ Documentation/verification of my Academic Degree. (i.e., copy of degree or transcripts). Please review Section 4.900 of the SOMB *Standards and Guidelines*.
- ☐ Documentation/Verification of my graduation from accredited APA school. Please review Section 4.900 of the SOMB *Standards and Guidelines*.
- ☐ Letter of reference.
- ☐ This signed application entitled **“First Application for Associate Level.”**

Additionally:

- ☐ I have completed the fingerprint registration process. I am scheduled to provide my fingerprints on _____.

Statement of Understanding

Initial _____

1. I understand that the information I have submitted on this application for the Sex Offender Management Board Provider List will be used for the following purposes:

- A. To conduct criminal history checks and background investigations as necessary.
- B. To create and disseminate a provider list of treatment providers, evaluators, and/or polygraph examiners.

2. My application materials will become a public record of the Division of Criminal Justice and may be subject to open record act requests pursuant to Section 24-72-304, C.R.S.

3. Inclusion on the provider list does not constitute certification or licensure and should not be represented as such. It does not create an entitlement or guarantee that I will receive referrals. If I am approved to be on the Provider List, it means that I am eligible to be considered as a provider of evaluation, assessment, treatment, and/or behavioral monitoring services for convicted sex offenders and/or adjudicated juveniles who have committed a sexual offense, pursuant to Section 16-11.7-106, C.R.S. which states:

“(1) The department of corrections, the judicial department, the division of criminal justice of the department of public safety, or the department of human services shall not employ or contract with and shall not allow a sex offender to employ or contract with any individual or entity to provide sex offender evaluation or treatment services pursuant to this article unless the sex offender evaluation or treatment services to be provided by such individual or entity conforms with the standards developed pursuant to Section 16-11.7-103(4) (b).”

(2) The board shall require any person who applies for placement on the list of persons who may provide sex offender treatment services pursuant to this article to submit a complete set of his or her fingerprints. The board shall forward any such fingerprints received pursuant to this subsection (2) to the Colorado Bureau of Investigation for use in conducting a state criminal history record check and for transmittal to the federal bureau of investigation for a national criminal history record check. The board shall use the information obtained from the state and national criminal history record check in determining whether to place the person on the approved provider list.

4. The Sex Offender Management Board will release information to all referring agencies regarding the status of my application, my placement on the Provider List, founded complaints, removal from the Provider List or denial of my application to the Provider List.

5. In the event a complaint is filed against me, the contents of my application will be reviewed by the Sex Offender Management Board in accordance with the Sex Offender Management Board Administrative Policies.

6. I have read the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* and/or the *Standards and Guidelines for the Evaluation, Assessment, Treatment, and Supervision of Juveniles Who Have Committed Sexual Offenses* in its entirety, including any revisions, and I understand and agree to carry out the *Standards* to the best of my ability related to the listing and level for which I am applying. I have answered all questions on this application honestly and the answers are complete to the best of my knowledge. I further understand that false statements or misstatements on this application are grounds for removal from the SOMB Provider Lists.

Continues of next page

Statement of Understanding

- _____ 7. You **must** notify the SOMB, in writing, within two weeks, of any changes to your name, address, telephone number, program name, program materials, clinical supervisor (*submit a revised supervision agreement if your supervisor changes*) or if you have added an additional treatment location. This should be done as soon as possible to avoid administrative problems and ensure accurate placement on the approved provider list. If the staff of the SOMB cannot locate you or reach you, your name will be removed from the approved provider list.
- _____ 8. I am in good standing and adhering to all the requirements with the American Polygraph Association (APA). I **must** provide the SOMB, in writing, within ten days, any changes to your professional status, such as grievances, license revocations, criminal charges/arrest or any other change in your professional standing. (Please reference the Administrative Policies in the SOMB *Standards*).

Printed Name of Applicant: _____

Signature of Applicant: _____ Date: _____

Printed Name of Clinical Supervisor: _____

Signature of Clinical Supervisor: _____ Date: _____

Qualifications of Polygraph Examiners

Adult and Juvenile Applicants

It is ***strongly*** recommended that you reference the following Standards while completing this section.
Adult and Juvenile Standards, Section 4.700 and 4.800

Associate Level Polygraph Examiners provide polygraphs under the supervision of a Full Operating Level Polygraph Examiner.

Please use the following list to determine if you meet the qualifications.

	Associate Level Polygraph Examiner
<input type="checkbox"/>	Bachelors Degree and graduation from accredited APA school [Section 4.800 (A)]
<input type="checkbox"/>	No history of criminal behavior related to the ability of the applicant to practice under the Standards [Section 4.90 (F)]
<input type="checkbox"/>	Written supervision agreement with a Full Operating Level Polygraph Examiner [Section 4.710]
<input type="checkbox"/>	A minimum of two (2) hours of one-to-one direct supervision monthly.

Standards of Practice for Polygraph Examiners

Adult and Juvenile Applicants

It is strongly recommended that you reference the following Standards while completing this section.
Adult and Juvenile Standards, 4.900

- Please submit documentation of your graduation from an accredited American Polygraph Association Program.
- _____ (Please initial) I understand that I shall engage in the peer review of my examinations by other polygraph examiners registered at the Full Operating Level.

Qualifications and Standards of Practice for Polygraph Examiners Developmental Disabilities (DD) Specialty

Adult & Juvenile Applicants

Please use this checklist to determine if you meet the conditions to apply for the DD Specialty.

Associate Operating Level Polygraph Examiner



Must have a supervisor with a specialty in examining sex offenders with DD.
[Section 4.920 DD]

Professional Supervision Agreement for Associate Level Polygraph Examiners

Adult and Juvenile Applicants

You may copy this page.

Applicants Name: _____

Date: _____

Supervisor's Name: _____

Agency: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Fax: _____ Email: _____

Please note that a relative of the applicant shall not provide supervision.

I understand that _____ is practicing under my SOMB listing status, and that I
Print Applicant's Name
am responsible for their supervision. I am adhering to the SOMB Standards and Guidelines along with the Administrative Policies. I hereby verify that I will sign off on all polygraphs conducted by the applicant in accordance with the SOMB Standards and Guidelines.

If any of your personal or professional information changes, you must report the information to the SOMB within two weeks.

Supervisor's signature _____ Date _____

Applicant's signature _____ Date _____

4.920: Professional Supervision of Associate Level Polygraph Examiners:

*The supervision agreement shall specify supervision occurring at a minimum of **two (2) hours** of one-to-one direct supervision monthly, and that the supervisor is ultimately responsible for the test results.*

How to Submit Fingerprints

Per Colorado Revised Statute 16-11.7-106(2), applicants must submit one set of fingerprints for use by the Colorado Bureau of Investigation (CBI) and for transmittal to the Federal Bureau of Investigation (FBI). Fingerprints are submitted electronically. Additionally, all new applicants are required to submit fingerprints *unless you already have submitted a card to the Domestic Violence Management Board or to the Sex Offender Management Board.*

There are two approved vendors providing fingerprinting services on behalf of CBI and each vendor has multiple locations throughout Colorado. You must initiate the process through the vendor's website. When you register you will need the following information:

Colorado Fingerprinting
<http://www.coloradofingerprinting.com>

CBI Unique Code: 3906SOBI
Reason Fingerprinted: CONCJ3906

IdentoGo
<https://www.identogo.com>

Service Code: 25YH45
Reason Fingerprinted: CONCJ3906