

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

**Application 3
Renewal of Current Listing**

**as a
POLYGRAPH EXAMINER
for the
Adult and Juvenile Provider List**



**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



COLORADO
Department of Public Safety

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?

This application should be completed by individuals who have been Associate Level Examiners for a minimum of one year, or individuals (Associate Level Examiner, Clinical Supervisor) or moving up (Full-Operating, Clinical Supervisor), and who are providing services to convicted adult sex offenders and/or adjudicated juveniles who have committed a sexual offense. Applicants must demonstrate that they meet ALL of the qualifications pursuant to the requested listing status. Applicants must also comply with standards of practice contained in the *Standards and Guidelines* published by the Colorado Sex Offender Management Board (SOMB). Please note, applicants shall apply as individuals, not as partnerships or programs.

Treatment Providers/Evaluators should not submit this form.

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 clinical 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 & Guidelines*. The applicant should first read and understand the *Standards and Guidelines* 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 the required attachments 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 application materials and current *Standards and Guidelines* are available at <https://www.colorado.gov/dcj> or by contacting (303) 239-4526.
- 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, a mechanism to receive and investigate complaints within the policies established for such complaints and via Standards Compliance Reviews according to SOMB policy and procedures.

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**.
8. ALL applicants MUST submit a money order or check for **\$125.00** made payable to **Colorado Department of Public Safety**. This is utilized to for the cost of your background check pursuant to C.R.S. and current Standards, which is required every three years. This fee is **NON-REFUNDABLE**.

APPLICANT NAME: _____

DATE: _____ **Provider #:** _____
(SOMB use only)

**For Continued Placement on the Sex Offender Management Board's Provider List as a Polygraph Examiner.
Adult and Juvenile Application**

You may also remove any pages not applicable to your application status.

Please check the categories) for which you are applying

ADULT POLYGRAPH EXAMINER

FULL OPERATING LEVEL

ASSOCIATE LEVEL

DEVELOPMENTAL DISABILITIES SPECIALTY

JUVENILE POLYGRAPH EXAMINER

FULL OPERATING LEVEL

ASSOCIATE LEVEL

DEVELOPMENTAL DISABILITIES SPECIALTY

Background and Identifying Information

Adult and Juvenile Applicants

This information will be used by SOMB staff to conduct a criminal history check, a background investigation, and to document your qualifications.

Applicant Name: _____

Credentials (MA, LCSW, etc.): _____

Aliases: _____

Gender: Male Female Date of Birth: _____

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

Home Phone: _____

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.

Employer Name: _____

Primary Business Address: _____

County of Primary Location: _____

Telephone: _____ Fax: _____ Email: _____

You may list up to five addresses and counties on the provider list. Please list the **full address**, the **County**, and **circle Adult Juvenile or Both**.

1. _____ County: _____

Adult/Juvenile/Both

2. _____ County: _____

Adult/Juvenile/Both

3. _____ County: _____

Adult/Juvenile/Both

4. _____ County: _____

Adult/Juvenile/Both

5. _____ County: _____

Adult/Juvenile/Both

Please list languages, other than English, which you speak fluently and in which you can demonstrate clinical proficiency (*this information will be published on the Provider List*):

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 or Full Operating 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

Recent Employment History (Attach Resume)

Adult and Juvenile Applicants

If your place(s) of employment and/or position has changed within the last three (3) years (i.e. since your last application) please provide that information below. A resume or curriculum vitae will also suffice if you wish to submit a copy. If nothing has changed please check the N/A box.

N/A

<i>Employer/Business Name:</i>		<i>Telephone:</i>
<i>Street Address:</i>		
<i>City:</i>	<i>State:</i>	<i>Zip Code:</i>
<i>Position:</i>	<i>Dates of Employment:</i> <i>From</i> <i>To</i>	
<i>Unless you were self-employed, list supervisor name:</i>	<i>Telephone:</i>	
<i>If self-employed, provide the name of a professional reference to verify this employment:</i>	<i>Telephone:</i>	
<i>Summary of job duties:</i>		
<i>Reason for leaving:</i>		

You may substitute a professional resume if it provides all the information requested.

<i>ACADEMIC DEGREE</i>	<i>SPECIALTY AREA</i>	<i>DATE OF DEGREE</i>	<i>NAME OF COLLEGE OR UNIVERSITY</i>	<i>LOCATION-CITY & STATE</i>
<i>B.A./B.S.</i>				
<i>M.A., M.S., M.S.W.</i>				
<i>Ed.D.</i>				
<i>Ph.D.</i>				
<i>Psy.D.</i>				
<i>Psychiatric Clinical Nurse</i>				
<i>M.D.</i>				
<i>Board Certified:</i>	<i>_____ Yes _____ No</i>			
<i>Other (describe)</i>				

- Have you ever received a written reprimand at any place of employment?

NO YES If yes, please explain.

- Have you ever been suspended, fired, or asked to resign from a position or employment?

NO YES If yes, please explain.

- Have you ever been arrested, charged or convicted of any criminal offense?

NO YES If yes, please explain.

- Have you ever been convicted of, or received a deferred judgment for, any offense involving criminal sexual or violent behavior?

NO YES If yes, please explain.

- Have you ever been convicted of a felony?

NO YES If yes, please explain.

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 as a mental health provider with the Department of Regulatory Agency. 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: _____

References

Adult and Juvenile Re-Applicants

- The Sex Offender Management Board background investigator will contact a minimum of four of the six references as part of the background check.
- All references must be familiar with your sex offense specific work and at least two (2) of the references listed must be members of a Community Supervision Team (CST) and/or Multidisciplinary Team (MDT) in which you participate.
- If you are applying as an **Adult AND Juvenile Provider**, please provide references that can speak about your ability to work with **BOTH** populations.

PROFESSIONAL REFERENCES

Name: _____ Position: _____

Address: _____

Telephone number: _____ Email: _____

Name: _____ Position: _____

Address: _____

Telephone number: _____ Email: _____

Name: _____ Position: _____

Address: _____

Telephone number: _____ Email: _____

REQUIRED ADDITIONAL REFERENCES - **Must** be familiar with your offense-specific work.

SUPERVISING OFFICER, PROBATION/PAROLE

Name: _____

Position: _____

Address: _____

Telephone number: _____ Email: _____

Continues on next page

POLYGRAPH EXAMINER, TREATMENT PROVIDER, EVALUATOR, OR OTHER - Please indicate the individual's profession below.

Name: _____

Position: _____

Address: _____

Telephone number: _____ Email: _____

POLYGRAPH EXAMINER, TREATMENT PROVIDER, EVALUATOR, OR OTHER - Please indicate the individual's profession below.

Name: _____

Position: _____

Address: _____

Telephone number: _____ Email: _____

Specialized Training

Adult and Juvenile Re-Applicants

This form is required for all applicants.

- Training attendance over the past **three (3) years (since your last reapplication)** will be considered. Please reference section 4.960 regarding specific training requirements.
- Specialized training is important to obtain since there is currently no graduate curriculum specialty area of sex offender treatment. Although you may have received excellent supervision, you **may not** use supervision as “training.”
- Generally, the length of the workshop or training equals hours of training.
- You may count e-learning and CD/DVD trainings for **half (1/2) credit**. Actual courses or webinar trainings can count for full credit.
- If you were the trainer, you may count the training you conducted as long as it does not exceed more than half of your total hours.
- Only 25% of the total required training hours can be comprised of in-house training within your agency/program.
- Please note the SOMB Standards requires that every three (3) years the provider shall complete forty (40) hours of training, which includes the SOMB Introductory training to the Standards or the SOMB Standards Booster training. Please review Section 4.000 for specific training requirements.
- You may count committee participation at 1 hour per meeting with a maximum of 6 hours which can be applied to the required number of training hours.
- **The SOMB staff may request copies of training certificates at any time and may conduct standard compliance reviews.**

BY SIGNING THIS FORM YOU ARE ATTESTING TO THE FACT THAT YOU HAVE ATTENDED THE TRAINING REQUIRED ACCORDING TO THE COMPETENCY-BASED PROVIDER APPROVAL MODEL RESPECTIVE TO YOUR SPECIFIC LISTING STATUS.

Polygraph Examiner Signature

Date

Supervisor Signature

Date

Clinical Experience

Adult and Juvenile Re-Applicants

This form is to be used for documentation of the number of exams you have accumulated within the last **three (3) years** (since your last application).

Please designate in the column below if your exams count toward Child Contact Assessment (“CCA”) or developmental disabilities (“DD”), if applicable. Be as specific as possible.

You may copy this page.

ADULT

DATES	Number of polygraph exams	“DD” or “CCA” (if applicable)	LOCATION or AGENCY
From:			
To:			
From:			
To:			
From:			
To:			
From:			
To:			

JUVENILE

DATES	Number of polygraph exams	“DD” (if applicable)	LOCATION or AGENCY
From:			
To:			
From:			
To:			
From:			
To:			
From:			
To:			

Professional Supervision Agreement for Associate Level Polygraph Examiners

Adult and Juvenile Re-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, _____ do hereby verify that I have provided _____ hours
(Supervisor) (Number of)
of supervision per month to the above named individual. These supervision hours were provided
at: _____.

(Agency Name)
Between _____ and _____
(Start Date) (End Date or Today's Date)

I hereby verify that I have signed off on _____ polygraphs conducted by the applicant.
(Number of)

I understand that _____ is practicing under my SOMB listing status, and
Print Applicant's Name
that I 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.

Supervisor's signature: _____ Date: _____

Applicant's signature: _____ Date: _____

Qualifications of Polygraph Examiners

Adult and Juvenile Re-Applicants

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

Full Operating Level Polygraph Examiners may operate without ongoing supervision specific to polygraph examinations, and may supervise Associate Level Polygraph Examiners and Intent to Apply applicants.

The following checklist will help you determine which level applies to you.

Associate Level Polygraph Examiner	Full Operating Level Polygraph Examiner
<input type="checkbox"/> Bachelors Degree and graduation from accredited APA school? [Section 4.900 (A)]	<input type="checkbox"/> Bachelors Degree and graduation from accredited APA school? [Section 4.960 (A)]
<input type="checkbox"/> Minimum of two (2)hours of one-to-one direct supervision monthly. [Section 4.920]	
<input type="checkbox"/> Written supervision agreement with a Full Operating Level Polygraph Examiner? [Section 4.920]	
<input type="checkbox"/> 40 hours of specialized training in 3 years? Must Include Standards Introduction or Booster Training [Section 4.930 (C)]	<input type="checkbox"/> 40 hours of specialized training in 3 years? [Ten (10) hours must be Sex Offender Specific) [Section 4.960 (D)] Must include Standards Introduction or Booster Training.
<input type="checkbox"/> Conducted 50 (Adult and Juvenile) post-conviction sex offense specific issue exams in last 3 years? [Section 4.930(B)]	<input type="checkbox"/> Conducted a minimum of 200, (Adult and Juvenile) post-conviction sex offense specific issue exams? [Section 4.960 (C)]
<input type="checkbox"/> Quality assurance protocols from 3 different polygraph examinations to three Full Operating Level Polygraph Examiners outside of your agency? [Section 4.930 (E)]	<input type="checkbox"/> Quality assurance protocols from 3 different polygraph examinations to three Full Operating Level Polygraph Examiners outside of your agency? [Section 4.970 (D)]
<input type="checkbox"/> No conviction or deferred judgment for felony criminal sexual or violent behavior related to the ability of the applicant to practice under these Standards? [Section 4.930 (G)]	<input type="checkbox"/> No conviction or deferred judgment for felony criminal sexual or violent behavior related to the ability of the applicant to practice under these Standards? [Section 4.970 (F)]
<i>If ALL of your answers YES then apply at this level. If not, go to the column on the right.</i>	<i>If ALL of your answers YES then apply at this level.</i>

Standards of Practice for Polygraph Examiners

Adult and Juvenile Re-Applicants

Attachments:

ADULT:

- ❑ Please send **one (1)** polygraph examination (preferably a sex history) including charts, hand scoring, and the written report conducted on convicted adult sex offenders to three different Full Operating Level SOMB approved/listed polygraph examiners outside your agency. Please **redact** client identifying information and instruct the examiners to forward all materials, including the quality assurance protocol form to the SOMB for review.

JUVENILE:

- ❑ Please send **one (1)** polygraph examination (preferably a sex history) including charts, hand scoring, and the written report conducted on adjudicated juveniles who have committed sex offenses to three different Full Operating Level SOMB approved/listed polygraph examiners outside your agency. Please **redact** client identifying information and instruct the examiners to forward all materials, including the quality assurance protocol form to the SOMB for review.

BOTH ADULT & JUVENILE:

- ❑ If you are applying for **both** adult and juvenile polygraph examiner, please send **two (2)** polygraph examinations, (preferably a sex history, one (1) each population) including charts, hand scoring, and the written report to three different Full Operating Level SOMB approved/listed polygraph examiners outside your agency. Please **redact** client identifying information and instruct the examiners to forward all materials, including the quality assurance protocol form to the SOMB for review.

DEVELOPMENTAL/INTELLECTUAL DELAY

- 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.

Application Type	Number of exams to Submit per population	To obtain DD /ID qualification	Total Needed for Adult and Juvenile Approval with DD/ID
Associate Level – First 3 years	3 Adult 3 Juvenile	One of total number must be DD/ID	6
Continued Associate Level	1 Adult 1 Juvenile	Additional exam needed (1)	3
Move to Full Operating	3 Adult 3 Juvenile	One of total number must be DD/ID	6
Continued Placement - Full Operation	1 each population	Additional Needed	3

Checklist for Attachments Standards of Practice for Polygraph Examiners

Adult and Juvenile Re-Applicants

Adult Quality Assurance Exams

Exam Type	Reviewing Examiner:	DD/ID
<input type="checkbox"/> Adult Maintenance/ Monitoring		Y / N
<input type="checkbox"/> Adult Sex History		Y / N
<input type="checkbox"/> Adult Specific Issue		Y / N

Juvenile Quality Assurance Exams

Exam Type	Reviewing Examiner:	DD/ID
<input type="checkbox"/> Juvenile Maintenance/ Monitoring		Y / N
<input type="checkbox"/> Juvenile Sex History		Y / N
<input type="checkbox"/> Juvenile Specific Issue		Y / N

Please remember to keep a copy of this for your records

Standards of Practice for Polygraph Examiners

Adult and Juvenile Re-Applicants

- Please submit the **names** and **contact information** of the Full Operating Level Polygraph Examiner(s) with whom you engage in peer review activities. (Please note they should not be within your agency.)

Name: _____ Agency: _____

Phone/Email: _____

1. _____

2. _____

3. _____

Qualifications of Polygraph Examiners Developmental Disabilities (DD) Specialty

Adult Re-applicants

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

Associate Level Polygraph Examiner	Full Operating Level Polygraph Examiner
<input type="checkbox"/> Must have a supervisor with a specialty in examining DD sex offenders with. [Section 4.920 DD]	
<input type="checkbox"/> Must submit documentation related to experience and knowledge of working with DD sex offenders. [Section 4.900 DD]	<input type="checkbox"/> Must submit documentation related to experience and knowledge of working with DD sex offenders. [Section 4.900 DD]
<input type="checkbox"/> Must combine another DD sex offender	<input type="checkbox"/> Must submit ADDITIONAL QA Exam on a DD Sex Offender (Adult or Juvenile)

Standards of Practice for Polygraph Examiners

Developmental Disabilities (DD) Adult

Adult Re-applicants

Attachments:

- ❑ Please describe how your polygraph examinations of sex offenders with developmental disabilities differ from your polygraph examinations of sex offenders without developmental disabilities. Please limit your response to one page.

- ❑ Please send a copy of one (1) representative polygraph examination including charts, hand scoring, and the written report for a sex offender with developmental disabilities to a Full Operating Level SOMB approved Polygraph Examiner with the DD Specialty for quality assurance. Please **redact** all identifying client information and indicate that the exam is an example of a developmental disability polygraph exam. Please instruct the examiner to forward all materials, including the quality assurance protocol form, to the SOMB for review. *Please note this exam can count toward the three total exams indicated above.*

Qualifications of and Standards of Practice for Polygraph Examiners

Developmental Disabilities (DD) Specialty

Juvenile Re-applicants

It is ***strongly*** recommended that you reference the following Standards while completing this section.
Juvenile Standards 4.300 DD and 4.720 DD

Note: JWCSO-DD means “*juveniles who commit sexual offenses and who have developmental disabilities.*”

- ❑ Please describe how your polygraph examinations of JWCSO-DD differ from your polygraph examinations of JWCSO who do not have DD. Please limit your response to one page.
- ❑ Please attach one (1) representative JWCSO-DD polygraph, if available. Please redact identifying client information. Please indicate in your narrative if exam is not available for QA.
- ❑ Please attach a letter describing the experience and training (and supervision if you are at the Associate Level) you have accrued that is specific to JWCSO-DD. Please limit your response to one page.

Professional Supervision Agreement For Associate Level Polygraph Examiners

Adult and Juvenile Re-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, _____ do hereby verify that I have provided _____ hours
(Supervisor) (Number of)
of supervision per month to the above-named individual. These supervision hours were provided
at: _____.
(Agency Name)

Between _____ and _____
(Start Date) (End Date or Today's Date)

I hereby verify that I have signed off on _____ polygraphs conducted by the applicant.
(Number of)

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.

Supervisor's signature: _____ Date: _____

Applicant's signature: _____ Date: _____

Request for Waiver of Qualifications of Treatment Providers and/or Evaluators

Adult and Juvenile Applicants

I _____, am requesting a waiver of certain criteria for the Qualifications of
Print Applicant's Name
Treatment Providers and/or Evaluators. I understand that due to my lack of being able to provide all required documentation or information required by the SOMB Standards, there may be certain conditions I must agree to in order to obtain approval of the requested listing.

Please indicate which requirement you wish to have waived below and provide an explanation as to why you have not been able to meet this requirement.

- Professional Reference
 - o Type: _____

Please explain:

- Training Requirements
 - o Introduction or Booster

If yes, please explain:

- o Hours Requirement:
 - Amount Completed: _____

If yes, please explain:

Other: _____

Please explain:
