Colorado Sex Offender Management Board (SOMB)

APPLICATION 2
Initial Three Year and/or Change of Status Application

for Placement on the Adult and/or Juvenile Provider List

Associate and Full Operating Level Treatment Provider, Evaluator, Clinical Supervisor, and/or Developmental Disabilities Specialty

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

January 2021

What Application Should I Be Using?

Application 1 – First Application for Associate Level

Application 1 is used when a provider is applying to SOMB for the first time for a 12-month initial listing. Application 1 is also used when adding on to your listing (e.g. adding DD Specialty or Evaluator status).

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

Application 2 is used when a provider has completed Application 1, 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 anytime you are changing your status (e.g. moving from Associate Level to Full Operating Level).

Application 3 – Renewal of Current Listing as Associate Level, Full Operating Level, and/or Clinical Supervisor

This application is used when a provider has completed Application 2, completed a three (3) year listing, and is renewing the 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 Providers for a minimum of one year, or individuals who are renewing a status (Evaluator, Developmental/Intellectual Disabilities, 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.

Polygraph examiners should not submit this form.
Please see Polygraph Examiner 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 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. Providers applying for the Initial Three Year Associate Level MUST submit a money order or check for **$125.00** made payable to **Colorado Department of Public Safety.** This is utilized 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.**

****Providers applying for Change of Status do not need to submit payment.*****

APPLICANT NAME: _____

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

For Placement on the Sex Offender Management Board's Provider List as a Treatment Provider and/or Evaluator.

Adult and Juvenile Application

Please check the categories for which you are applying

◯ **INITIAL THREE YEAR ASSOCIATE** ◯ **CHANGE OF STATUS**

☐ **ADULT ASSOCIATE LEVEL TREATMENT PROVIDER**

_____DEVELOPMENTAL/INTELLECTUAL DISABILITIES SPECIALTY

☐ **ADULT ASSOCIATE LEVEL EVALUATOR**

_____ DEVELOPMENTAL/INTELLECTUAL DISABILITIES SPECIALTY

☐ **ADULT FULL-OPERATING LEVEL TREATMENT PROVIDER**

_____ DEVELOPMENTAL/INTELLECTUAL DISABILITIES SPECIALTY

☐ **ADULT FULL-OPERATING LEVEL EVALUATOR**

_____ DEVELOPMENTAL/INTELLECTUAL DISABILITIES SPECIALTY

☐ **JUVENILE ASSOCIATE LEVEL TREATMENT PROVIDER**

_____ DEVELOPMENTAL/INTELLECTUAL DISABILITIES SPECIALTY

☐ **JUVENILE ASSOCIATE LEVEL EVALUATOR**

_____ DEVELOPMENTAL/INTELLECTUAL DISABILITIES SPECIALTY

☐ **JUVENILE FULL-OPERATING LEVEL TREATMENT PROVIDER**

_____ DEVELOPMENTAL/INTELLECTUAL DISABILITIES SPECIALTY

☐ **JUVENILE FULL-OPERATING LEVEL EVALUATOR**

_____ DEVELOPMENTAL/INTELLECTUAL DISABILITIES SPECIALTY

☐ **CLINICAL SUPERVISOR**

Background and Identifying Information

Adult and Juvenile Re-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: _____

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

_____

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 (Phone)

2._____ County: _____
Adult/Juvenile/Both (Phone)

3._____ County: _____
Adult/Juvenile/Both (Phone)

4._____ County: _____
Adult/Juvenile/Both (Phone)

5._____ County: _____
Adult/Juvenile/Both (Phone)

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 one or more of the following: **Associate Level Treatment Provider, Associate Level Evaluator, Full Operating Level Treatment Provider, Full Operating Level Evaluator, Developmental Disability Specialty, Clinical Supervisor.** 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

Please list your place(s) of employment and positions for the last five years starting with your current or most recent employment. If you practiced psychotherapy in another state, with or without a license, please also include that work experience. You may substitute a professional resume if it provides all the information requested.

You may copy this page

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

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

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

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

- 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.

Background and Identifying Information Continued

ALL APPLICANTS WHO ARE NOT LICENSED **MUST** BE REGISTERED AS AN UNLICENSED PSYCHOTHERAPIST WITH THE DEPARTMENT OF REGULATORY AGENCIES (DORA) IN ORDER TO BE PLACED ON THE SOMB PROVIDER LISTS ***EVEN IF YOUR CURRENT EMPLOYMENT DOES NOT REQUIRE IT.***

- **Do you have a current Colorado license to practice psychotherapy?**

  ◯NO ◯YES

  (*A copy of your license must be attached to this application per sections (12-43-303; 12-43-403; 12-43-503; 12-43-603 C.R.S.)

  A. If you are not licensed:

  a. Are you an Unlicensed Psychotherapist?

  ☐ NO ☐ YES

  (*A copy of your registration must be attached to this application per sections (12-43-702.5, C.R.S.)

  *This requirement applies to ALL applicants, including Department of Corrections.

  b. **Are you in the process of applying for a Colorado license?**

  ☐ NO ☐ YES

  c. **Have you practiced psychotherapy without a license in any other state?**

  ☐ NO ☐ YES

  If yes, please list those states and include this experience in your employment history form.

- **Have you ever been licensed or certified to practice psychotherapy in any other states?**

  ☐ NO ☐ YES

  If Yes, please list those states and include this experience on the employment history page.

- **Have there ever been allegations about you engaging in unethical behavior by any licensing or certifying body in Colorado or any other state or jurisdiction?**

  ☐ NO ☐ YES

  If yes, please explain:

- **Have you ever had a license or certification revoked, canceled, suspended or have you been placed on probationary status by any professional licensing body? This includes**

any previously successful or currently pending challenge to your licensure, certification or registration.

☐ NO ☐ YES

If yes, please explain:

- **Have you ever voluntarily relinquished a license or certification to provide psychotherapy?**

☐ NO ☐ YES

If yes, please explain:

- **Have you ever voluntarily or involuntarily limited, reduced or lost any clinical or mental health staff privileges?**

☐ NO ☐ YES

If yes, please explain:

- **Do you have any pending professional liability or malpractice actions, or final judgments or settlements involving your professional practice?**

☐ NO ☐ YES

If yes, please explain:

Initial

Statement of Understanding

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.

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.

Continues on next page

Statement of Understanding

8. I am in good standing as a mental health provider and adhering to all the requirements with the Department of Regulatory Agencies (DORA). I **must** provide the SOMB, in writing, within ten days, any changes to my professional status, such as grievances, license revocations, criminal charges/arrest or any other changes to my professional standing. (Please reference the Administrative Policies in SOMB standards).

Printed Name of Applicant:

Signature of Applicant: Date:

Printed Name of Clinical Supervisor: _____

Signature of Clinical Supervisor: _____ Date: _____

References

- 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.
  - **DOC/DYC EMPLOYEES: Since you may not be working with CST and/or MDT Teams you may provide names other professionals familiar with your sex offense specific work**.
- If you are applying as an **Adult AND Juvenile Provider**, please provide references that can speak about your ability to work with **BOTH** populations.
- If you are not providing direct clinical services, please submit six references that are familiar with your work as it pertains to your work in the field of sex offender treatment and/or evaluation.

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

VICTIM ADVOCATE, VICTIM THERAPIST, VICTIM REPRESENTATIVE OR OTHER VICTIM PROFESSIONAL - You must have a victim reference. If you don't, please contact the Adult Standards Coordinator or the Juvenile Standards Coordinator.

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

This form is required for all applicants.

- Training attendance will be considered for the past **five (5)** years. Please reference section 4.000 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 clinical supervision, you **may not** use clinical supervision as "training."
- Generally, the length of the workshop or training equals hours of training**.** FOR CONFERENCES, YOU **MUST ITEMIZE EACH WORKSHOP** ON A SEPARATE LINE.
- 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 states the provider shall complete forty (40) hours of training, which includes the SOMB Introductory training to the Standards or the SOMB Standards Booster training. This is required for initial listing, movement to full operating level and at each renewal period. **A copy of your certificate is required**. 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 will conduct standard compliance reviews.**

You may copy this page.

DATES	HOURS	TITLE OF TRAINING	SPONSOR/TRAINER	Adult, ("A") Juvenile ("J") or Both ("AJ")
1/4/2012	*6*	*Victims of Sexual Assault*	*Jerry Smith, L.P.C. NEARI Press*	*A J*

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

_____ _____

Printed Name of Applicant Signature of Applicant Date

_____ _____

Printed Name of Clinical Supervisor Signature of Clinical Supervisor Date

Professional Supervision Agreement For Associate Level Treatment Providers and/or Evaluators:

Adult and Juvenile Applicants

I understand that _____ is practicing under my licensure and SOMB listing
Print Applicant's Name
status, and that I am responsible for their clinical supervision. I am adhering to the SOMB Standards and Guidelines along with the SOMB Administrative Policies and have developed an individualized comprehensive supervision plan for _____ in accordance with the
Print Applicant's Name
Competency Based Provider Approval Model and will have it available for the Application Review Committee upon request.

If any of your information changes, including a change with supervision, you must report the information to the SOMB within two weeks.

Applicant's Name (Please Print Clearly) _____

Applicant's signature: _____Date: _____

Supervisor's Name (Please Print Clearly)_____

Supervisor's signature: _____Date: _____

The frequency of face-to-face supervision hours specific to sex offense specific treatment and/or evaluation calculated as follows:

Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month
0-59	2
60-79	3
80 or more	4

Will you be utilizing alternate forms of supervision, i.e., phone, video conferencing? Yes ◯ No ◯
If yes, please explain:

Qualifications of Treatment Providers and/or Evaluators

Adult and Juvenile Applicants

Required Attachments*

Associate Level Applicants applying for their initial three listing must provide the following attachments:

- One (1) copy of a recent offense-specific treatment plan and one (1) copy of an evaluation with redacted client identifying information. If you are currently listed as a provider who treats clients with developmental and/or intellectual disabilities, the document(s) you attach must attest to your work with this specific population.
- An updated competency rating from your clinical supervisor for the past three years. Competency Assessments may be downloaded via the following link: https://www.colorado.gov/pacific/dcj/somb-provider-applications.
- A narrative as to how you are staying active in the field (which may include training, research you have read or participated in, and further information regarding current treatment, consultation or supervision practices you have engaged in during this renewal cycle).
- Evidence of registration as an Unlicensed Psychotherapist OR evidence of Licensure.
- Copy of your current Driver's License.
- $125.00 check or money order made out to Colorado Department of Public Safety.

Associate Level Applicants applying to move up to Full Operating Level must provide the following attachments:

- One (1) copy of a recent offense-specific treatment plan and one (1) copy of an evaluation with redacted client identifying information. If you are currently listed as a provider who treats clients with developmental and/or intellectual disabilities, the document(s) you attach must attest to your work with this specific population.
- An updated competency rating from your clinical supervisor for the past three years. Competency Assessments may be downloaded via the following link: https://www.colorado.gov/pacific/dcj/somb-provider-applications.
- A detailed letter from your clinical supervisor indicating his/her recommendation that you move to Full Operating Level status.
- A narrative as to how you are staying active in the field (which may include training, research you have read or participated in, and further information regarding current treatment, consultation or supervision practices you have engaged in during this renewal cycle).
- Evidence of registration as a Registered Psychotherapist OR evidence of Licensure.
- Copy of your current Driver's License.
- $125.00 money order or check made out to Colorado Department of Public Safety **Please note: If you are applying for a Change in Status (and not your three-year renewal) you do not need to submit the $125.00 fee.**

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 with 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:

Clinical Supervisors

Applicants may apply for approval as an SOMB Clinical supervisor once they have met the required qualifications and completed the following:

- ❑ Receive supervision from an approved SOMB clinical supervisor for assessment of their supervisory competence.
- ❑ Be assessed as competent in SOMB clinical supervisor Competency #1.
- ❑ Provide supervision, when deemed appropriate, under the oversight of their SOMB clinical supervisor.

Required Attachments

- A competency rating from your clinical supervisor. Competency Assessments may be downloaded via the following link: https://www.colorado.gov/pacific/dcj/somb-provider-applications.
- A detailed letter from your clinical supervisor indicating his/her recommendation that you move to Clinical Supervisor status.
- Please document attendance to the clinical supervisor training, if applicable.
- A narrative as to how you are staying active in the field (which may include training, research you have read or participated in, and further information regarding current treatment, consultation or supervision practices you have engaged in during this renewal cycle).