CATSO

**Connecticut Association for the Treatment of Sexual Offenders**

Attn: Dr. Lothstein

28 South Main Street, W Hartford, CT 06109

# Membership Application

I am applying for Clinical Membership in CATSO, which is for professionals with a Masters degree or above in a clinical field of study who have engaged in direct clinical assessment/treatment of sexual offenders for at least 1,000 hours under the supervision of a CATSO Clinical Member or other recognized sex offender treatment specialist.

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Date of Application

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Name Date of Birth

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Mailing Address (city, state, zip code)

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Email Address

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Home Phone Work Phone

LICENSE AND CERTIFICATION INFORMATION:

Please complete the following when applicable:

Licensed As: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE\_\_\_\_\_\_\_\_\_\_\_\_\_ #\_\_\_\_\_\_\_\_\_\_\_\_

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Other Certifications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever had a professional license/certification denied, revoked or suspended? YES\_\_\_ NO\_\_\_

Has there ever been a malpractice judgment against you? YES\_\_\_ NO\_\_\_

Has a finding of professional misconduct ever been made against you by a licensure or certification board or by the board of directors, ethics committee

or professional oversight board of any agency, institution or professional

organization where you worked or held membership? YES\_\_\_ NO\_\_\_

Have you ever been convicted of a felony? YES\_\_\_ NO\_\_\_

Have you ever been convicted of any charge related to sexual misconduct or assault

in any state or jurisdiction (felony or misdemeanor)? YES\_\_\_ NO\_\_\_ PROFESSIONAL EXPERIENCE:

CATSO Clinical Membership requires supervision by a CATSO Clinical Member or a professional who has recognized expertise in assessing and treating sexual offenders. If your supervisor was not a CATSO Clinical Member, please include information about your supervisor’s qualifications in sexual offender assessment & treatment.

Please list recent employment/experience first.

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1. Employer Supervisor

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Business Address (city, state, zip code)

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Major duties and responsibilities

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Hours in **direct** clinical assessment/treatment of sexual offenders: Per Week Total hours

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1. Employer Supervisor

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Business Address (city, state, zip code)

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Major duties and responsibilities

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Hours in **direct** clinical assessment/treatment of sexual offenders: Weekly Total hours

Please include any additional employment you have related to the assessment/treatment of sexual offenders on a separate page, utilizing the same format as above.

EDUCATION:

List most recent first, including the name and location of the institution, dates attended, degree, major and date completed:

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Please arrange to have an official transcript sent to CATSO. by the institution from which you obtained your highest degree. Your application will not be processed until the Membership Committee has received this transcript.

Provide a list any specialized training that you have received that is related to the assessment and treatment of sexual offenders, with dates and affiliations (e.g.; ATSA, MATSA).

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LETTERS OF REFERENCE:

Please list the names and current addresses of two treatment providers who are familiar with your professional and personal qualifications with respect to the work you have done with sexual offenders. One letter of reference must be from the primary supervisor of your professional experience in treating and assessing sexual offenders, who should be either a CATSO Clinical Member or a professional with recognized expertise in assessing and treating this population. You are responsible for sending the CATSO Letter of Reference forms to the individuals that you list below. The Membership Committee will not process this application until the Letters of reference are received.

Opinion is divided about whether reference letters that are not open to review are more helpful in assessing an applicant’s professional and personal credentials. Should you wish to waive your right to review your letters of reference, you may do so by signing the waiver on each letter of reference. In either case, your application will be carefully considered without prejudice.

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1. Name of Person Providing Reference Position

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Business Address (city, state, zip code) Phone

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Business Address (city, state, zip code) Phone

A non-refundable application fee of $25.00 is to be submitted with this form. In addition, please complete the Criminal Record Request form that can be obtained from the CATSO web site (www.catso.org) and send it to the Department of Public Safety, along with the current records request fee. The CATSO annual membership fee is $125.00, due January 31 of each year. To complete this form, please read and sign the statement that follows.

I certify that all of the information that I have provided for this application is truthful and accurate. I have read the Association’s By-Laws and Code of Ethical Principles, which are available on the CATSO website. If accepted as a member, I will support the objectives of the Association and will abide by the provisions of the Association’s By-Laws and Code of Ethical Principles.

Signature of Applicant Date of Application

PLEASE NOTE: All applications are reviewed first by the Membership Committee. If approved, applications are then voted at the next scheduled Board of Directors’ meeting. If you have questions about this process or wish to apply for membership, please address correspondence to Dr. Lothstein/CATSO, 68 South Main St., West Hartford, CT 06109 or contact Eileen at emredden@snet.net.

Checklist: \_\_\_\_\_\_ Completed and Signed Application Form

\_\_\_\_\_\_ Two Letters of Reference

\_\_\_\_\_\_ College Transcript Requested

\_\_\_\_\_\_ Completed criminal records form sent to Dept. Public Safety

\_\_\_\_\_\_ Non-Refundable Application Fee of $25.00

WAIVER OF STANDARD CRITERIA FOR MEMBERSHIP

If you do not meet all the criteria required for Clinical Membership, but believe that you have unique qualifications, experience, or circumstances that should qualify you for clinical status, please explain below. Your application will be reviewed first by the membership Committee and then, if a waiver of standard criteria is considered to be warranted, it will be voted upon by the Board of Directors of the Association. If a waiver of standard requirements for Clinical Membership is not granted, you may apply immediately for any other membership category, and re-apply for Clinical Membership at a later date. You will be notified of the decision regarding your application at the earliest possible date.

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**Signature of Applicant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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