## Application for LSOTP Specialized Competencies

Mail form with fee to: HHSC Accounts Receivable Mail Code 1470 P.O. Box 149055 Austin, TX 78714-9055

Service Code: 529201042

Phone (512) 438-5446 csot@hhs.texas.gov

Copy of your prima Application Questi Copy of Supervision population accrued Copy of document  Applicant Pro	n fee for each speciali ary license; onnaire; on Form(s), verifying a no more than seven y is to show at least 24	ized competency checked below. Post least 250 hours of experience wit years before the date of this application hours continuing education in each Please print or type.	h each specialized cor	npetency
LSOTP	Number	Date issued (mm/dd/yyyy)	Expi	res (mm/dd/yyyy)
Name	Last name	First name	Middle name	
Address	Street address	City	State	ZIP code
Email Address	Email address			
Female sex offend	nmit sexual offenses lers lelayed sex offenders			
ACKNOWLEDGMENTS FOR SPECIALIZED COMPETENCIES				
(Initial each statement and sign below)				
I have a minimum of 250 documented and verified hours of experience in the assessment and treatment of each population documented as a specialized competency accrued no more than seven years before the date of this application.				
•		rs of documented continuing educa pecialized competency.	tion in the assessmen	t and treatment
I will obtain 3 continuing education hours each renewal period in each specialized competency documented.				
I have read, und Chapter 810 (Co	•	e by Texas Occupations Code 110	and 22 Texas Admir	istrative Code,
I attest that I understand and meet all the requirements for documentation of the requested specialized competency. Further, I understand that it is a violation of the Texas Penal Code. Sec. 37.10, to submit a false statement to a government agency.				

Signature of Applicant

Date