



**CONTRACT OF SUPERVISION FOR
AFFILIATE SEX OFFENDER
TREATMENT PROVIDER (ASOTP) OR
PROVISIONAL SEX OFFENDER
TREATMENT PROVIDER (PSOTP)**

DSHS
PLCU/CSOT
MAIL CODE 2003
PO BOX 149347
Austin, TX 78714-9347
(512) 834-4530 PHONE
(512) 834-6677 - FAX

This form must be completed by each Licensed Sex Offender Treatment Provider (LSOTP) who agrees to accept supervision responsibility for the ASOTP or PSOTP

Name of ASOTP OR PSOTP _____ LICENSE # _____

Name of LSOTP: _____ LICENSE # _____

- The supervisee shall provide approximately _____ hours of sex offender treatment per week.
- Primary location of services rendered by Supervisor: _____
- Description of Sex Offender Treatment Services provided by Supervisor: _____
- Description of Sex Offender Treatment Services provided _____
- Supervision start date: _____

It is the RESPONSIBILITY of the ASOTP OR PSOTP *and* the LSOTP to notify the Council on Sex Offender Treatment, in WRITING, WITHIN ONE WEEK of termination of supervision.

I understand that an ASOTP OR PSOTP providing any sex offender treatment is required to be under the supervision of an LSOTP.

- I understand that an ASOTP or PSOTP shall receive face-to-face supervision at least one hour per month per 20 hours of assessment and treatment with a minimum of 2 hours per month during any time period in which the ASOTP or PSOTP provides sex offender treatment unless granted an exception by the Council.
- I understand that the supervising LSOTP shall submit biennial documentation to the council at the time of their renewal; the documentation shall contain the name of the ASOTP(s) or PSOTP(s) that have been supervised during the biennium.
- I understand that the ASOTP or PSOTP shall provide a copy of supervision documentation, to the council during the renewal period.

I shall abide by Occupations Code 110 and 22 Texas Administrative Code, Chapter 810 (Council Rules). I understand my duties and responsibilities.

Signature of ASOTP or PSOTP

Date

Signature of LSOTP

Date