

*Membership dues for the calendar year are* ***due by January 31 of the current calendar year****. Please send your membership before the due date.* ***California Coalition on Sexual Offending reserves the right to refuse allied membership to any individual that does not meet the membership criteria.***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Individual $75 |  |  | Student membership $35 (attach verification full-time student status) |  |  | Retired Professionals $35 |

***Make Checks Payable to CCOSO Mail to: CCOSO,*** 1626 Montana Ave. Suite 117, Santa Monica CA 90403

***This address will be published in CCOSO Directory. Please include separate forms for additional sites (single charge per person).***

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last Name: | |  | | | | | |  | First Name: | |  | | | | | | | |
| Address: |  | | | | |  | City: |  | | | |  | State: | |  | Zip: |  |
| Phone: |  | | | | |  | Fax: |  | | | |  | County: | |  | | |
| Email: | |  |  |  | License/Title: | | | | |  | | | |

CASOMB Certification level: \_\_\_\_Independent; \_\_\_Associate; \_\_\_Apprentice

***Employment Setting:***  Check here if you want this address used in the directory, rather than the address listed above.

|  |  |
| --- | --- |
| Company/Agency Name: |  |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Private Practice | | County Agency | | | | | | Non-Profit Agency | | | |
| Group/FFA  Hospital | | State Agency  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Institution  Federal Agency | | | |
| Address: |  | |  | City: |  |  | State: | |  | Zip: |  |
| Phone: |  | |  | Fax: |  |  | Email: | |  | | |

***Professional Discipline:***Job Title*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

|  |  |
| --- | --- |
| Profession: (Please explain how your work relates to sex offenders) |  |

***Regional Chapter Information: If you are not sure which chapter you belong to, check this box***

|  |  |  |
| --- | --- | --- |
| Bay Area | Inland Empire | Northern California |
| Central Coast | LA North | Orange County |
| Central Valley | LA South | San Diego |
| Fresno | North Coast | Out of State  Ventura/Santa Barbara |

***Other Professional Organizations are you a member of***:  APA  CPA  ATSA   
 AAMFT  CAMFT  CSAIA  CALCASA  NASW

***Language in which you are competent to deliver services****:*  English  Spanish  Other \_\_\_\_\_\_\_\_\_\_\_\_\_

***This table applies to mental health and residential treatment personnel only****. If you work in this field, please place a check mark in each box that indicates an activity, setting or modality you or your facility provide for a population.*

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| **Sex Offender Populations Served** | Adult female | Adult male | Adoles-cent female | Adoles-cent male | Develop-mently disabled adult | Develop-mently disabled adolescent | Sexually reactive children | Non-offending parents | Victims |
| ***Treatment Modalities*** | | | | | | | | | |
| Sex Offender Specific Groups |  |  |  |  |  |  |  |  |  |
| Individual Therapy |  |  |  |  |  |  |  |  |  |
| Family Therapy |  |  |  |  |  |  |  |  |  |
| Multisystemic, (Wraparound, etc.) |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| ***Assessment Methods*** | | | | | | | | | |
| Psychological Assessment & Evaluation |  |  |  |  |  |  |  |  |  |
| Neuro-Psych Assessment & Evaluation |  |  |  |  |  |  |  |  |  |
| Educational Assessment |  |  |  |  |  |  |  |  |  |
| Other (Plethysmograph, Polygraph, Abel) |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| ***Treatment Methods*** | | | | | | | | | |
| Cognitive Behavioral |  |  |  |  |  |  |  |  |  |
| Behavioral Conditioning |  |  |  |  |  |  |  |  |  |
| Psychodynamic |  |  |  |  |  |  |  |  |  |
| Family Systems |  |  |  |  |  |  |  |  |  |
| Multisystemic |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| ***Treatment Settings*** |  | | | | | | | | |
| Group Home |  |  |  |  |  |  |  |  |  |
| Outpatient Therapy |  |  |  |  |  |  |  |  |  |
| Hospital |  |  |  |  |  |  |  |  |  |
| Prison |  |  |  |  |  |  |  |  |  |
| Therapeutic Foster Care |  |  |  |  |  |  |  |  |  |