**Request for Inclusion on Commissioner’s List of Approved Evaluators**

(Competency to Stand Trial (§19.2-169.1) and/or Sanity at the Time of the Offense (§19.2-168.1, §19.2-169.5)

**Date**:

**Name**:     

**Name of Practice (if applicable):**

**Street Address:**

**City:**

**State and Zip Code:**

**Email Address:**

**Phone #:**      **FAX #:**

**EDUCATIONAL HISTORY:**

**Highest Degree Earned**:       **Year Earned**:

**Institution Awarding Degree**:

**Describe any specialized forensic training you received which prepares you to conduct Competency to Stand Trial and/or Sanity at the Time of the Offense Evaluations (add separate pages as needed)**:

|  |  |  |  |
| --- | --- | --- | --- |
| Description of Training | Institution Providing Training | Year of Training | Relevant for Competency, Sanity or Both |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**LICENSURE/ BOARD CERTIFICATION STATUS:**

**Are you licensed to practice in the Commonwealth of Virginia**:  Yes  No

**Agency Awarding License**:

**Licensed to Practice as**:

**Have you been awarded Board Certification/ Diplomat Status in Forensics**:  Yes  No

**If yes, name of institution/organization awarding this status**:

**FORENSIC EXPERIENCE:**

**Approximate number of Competency to Stand Trial evaluations completed during your career**:

**Approximate number of Sanity at the Time of Offense evaluations completed during your career**:

**TYPE OF REQUEST:**

**Requesting inclusion on Commissioner’s list for the following type of evaluations (check all that apply)**:

Competency to Stand Trial (§19.2-169.1)

Sanity at the Time of the Offense (§19.2-169.5 / §19.2-168.1)

**Geographic Area(s) of Practice:**

**I am willing and able to accept court appointments from the following regions (Check all that apply - specify if there are limited counties/cities in which you will accept appointments – See attached for description of regions):**

Northern (Any Restrictions):

Eastern (Any Restrictions):

Hampton Roads (Any Restrictions):

Valley (Any Restrictions):

Richmond Metro (Any Restrictions):

Central (Any Restrictions):

West Central (Any Restrictions):

Southside (Any Restrictions):

Southwestern (Any Restrictions):

**APPOINTMENT PREFERENCES (Check all that apply):**

I will accept any/all appointments from the Court(s) designated above

I prefer to be contacted first before being appointed to discuss availability

I prefer that Court Orders name my practice rather than me individually in the order (I understand that anyone completing the evaluation must meet the minimum standards and also be included on the Commissioner’s list)

I prefer that Court Orders be emailed to me/my practice

I prefer that Court Orders be FAXED to me/my practice

I prefer that Court Orders be sent via US Mail

I have the following preferences/ limits on my practice:

**ABILITY TO CONDUCT EVALUATIONS FOR NON-ENGLISH SPEAKERS (if applicable)**

I am competent to conduct evaluations for individuals who use the following languages:

I am competent to conduct evaluations using American Sign Language

**ATTESTATION:**

I hereby attest that the above provided information is truthful and accurate. I am licensed to practice as a psychiatrist or clinical psychologist. I am competent to complete the types of evaluations for which I’m requesting inclusion in the Commissioner’s list of approved evaluators. I understand and agree to comply with the requirements of the Code of Virginia to include submission of redacted work samples to the Dept. of Behavioral Health & Developmental Services (DBHDS) effective July 1, 2016. I understand that a random sample of evaluations will be subjected to peer review and I will be provided with feedback on my evaluations. I agree to notify DBHDS immediately should my license be suspended or revoked and agree to cease providing court appointed evaluations until such time as my license is in good standing. I further agree to notify DBHDS of any changes of address or other changes to my practice which would affect court appointments. Finally, I agree to notify DBHDS should I close my practice and/or desire to cease receiving court appointments so that I can be removed from the list of approved evaluators.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date