

You have requested placement in a Sex Offender Treatment Program (SOTP) in the Bureau of Prisons. All SOTP participants consent to the treatment conditions described below:

- I understand the potential benefits of participating in the SOTP, as described in the SOTP Program Description brochure.
- I acknowledge that staff have given me a copy of the SOTP Program Description brochure. Any questions I have about the content of the brochure have been answered to my satisfaction.
- I understand that the Bureau offers a high intensity residential Sex Offender Treatment Program (SOTP-R) and a moderate intensity non-residential Sex Offender Treatment Program (SOTP-NR), as explained in the SOTP Program Description brochure. Staff will review my request for placement in sex offender treatment to determine the most appropriate program for me based on my history and specific treatment needs. If I do not wish to enter the program designated by staff to meet my treatment needs, I will be afforded the opportunity to decline to participate, and my decision will be documented in my psychology records.
- I understand that the SOTP is a voluntary program. I may withdraw from the program at any time. I also understand that in order to participate in the program, I may be required to transfer to a facility assigned to me for SOTP participation.
- I understand that the SOTP consists of a variety of treatment activities, including therapeutic groups and individual sessions, psychological testing, feedback to other participants, feedback from treatment staff and other participants, and treatment community meetings (residential programs only). I understand that my full participation in all of these activities is essential to my success in treatment.
- I understand that all SOTP participants have an individualized treatment plan. I will have the opportunity to provide input into the development of my treatment plan.
- I understand that I am expected to protect the confidentiality and privacy of other participants in the treatment program. I understand there is no tolerance for breach of confidentiality.
- I understand that SOTP staff respect the privacy of inmates who disclose personal information. I understand there are limitations to my confidentiality in the program. I understand SOTP staff may release treatment information to other entities as permitted by law. I understand that if I disclose information about previously unreported abuse or neglect of a child, an elderly person, or an adult who is incapable of caring for him/herself, SOTP staff are required to report this conduct, as required by law. I understand that my SOTP records may be considered by the Bureau of Prisons when reviewing my case for possible certification as a sexually dangerous person pursuant to 18 U.S.C. 4248.
- I understand that I am expected to follow Bureau of Prisons policies, rules and regulations. I understand that if I fail to do so, I may be expelled from the program.

AGREEMENT/SIGNATURE

I have read, or have had this document read to me, and I understand and accept the rules and regulations for participation in the SOTP described in this agreement to participate.

Inmate Name Printed	Staff Name Printed
Inmate Signature	Staff Signature
Register Number	Staff Title
Date	Date