IDAHO DEPARTMENT OF CORRECTION
Sex Offender Chaperone Agreement

Offender’s name: ________________________________  IDOC#: ________________

1. Offenders are prohibited from any place identified in the Idaho Department of Correction (IDOC) Sex Offender Agreement of Supervision without an approved chaperone.

2. Chaperones must be willing and able to hold the offender accountable to treatment guidelines and conditions of probation or parole.

3. Chaperones must be willing and able to report any problems or concerns to the offender’s supervising probation and parole officer (PPO).

4. Approval of chaperone supervision is for specific, individual activities only as approved in writing by the supervising PPO. Sex offenders are not allowed to go to prohibited areas or activities with a chaperone unless it is approved in writing by the supervising PPO.

5. Chaperone privileges can and will be revoked for, but not limited to, the following issues:
   - If the chaperone is unable or unwilling to hold the offender accountable to the treatment guidelines and the conditions of probation or parole;
   - If the chaperone is unable or unwilling to report any problems or concerns to the offender’s supervising PPO; and
   - If the chaperone does not adhere to activity specified and approved as noted on the Sex Offender Supervision Activity Request and Sex Offender Supervision Activity Request Safety Plan; and/or if the chaperone escorts the offender into prohibited situations.

Proposed Chaperone’s Statement of Agreement

I have read or have had this agreement read to me, and I agree to these IDOC guidelines as written and as verbally explained to me. I am aware that upon being approved to be a chaperone, if I do not adhere to these IDOC guidelines, my chaperone status may be immediately revoked.

____________________________________________
Proposed Chaperone’s Printed Name
Proposed Chaperone’s Signature          Date

Witnesses (as applicable)

____________________________________________
PPO’s Printed Name
PPO’s Signature          Date

____________________________________________
Treatment Provider’s Printed Name
Treatment Provider’s Signature          Date

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