

AFFIDAVIT TO BE PLACED ON THE BATTERERS' INTERVENTION PROGRAM  
PROVIDER LIST IN THE \_\_\_\_\_ CIRCUIT

I, \_\_\_\_\_ [Authorized Representative's name], being duly sworn, hereby certify, swear and/or affirm that the following information is true and correct:

1. I am over 18 years of age, am *sui juris*, and am otherwise competent to make this affidavit.
2. I make this affidavit based upon my personal knowledge.
3. I am the \_\_\_\_\_ [Title or Position through which affiant is authorized] of \_\_\_\_\_ [Legal Name of Batters' Intervention Program provider] (BIP Provider).
4. I have the authority act on behalf of and to bind the BIP Provider.
5. The BIP Provider provides a batterer's intervention program course for individuals who have been ordered to attend a batterer's intervention program by the court.
6. I am aware that pursuant to s. 741.30(6)(a)5, Florida Statutes, when the court orders the respondent to participate in a batterers' intervention program, the court, or any entity designated by the court, must provide the respondent with a list of batterers' intervention programs from which the respondent must choose a program in which to participate. I am submitting this affidavit in order to have the BIP Provider placed on the list of eligible programs in \_\_\_\_\_ Circuit (Court).
7. The BIP Provider program meets each of the following requirements:
  - (a) The primary purpose of the program is victim safety and the safety of children, if present.
  - (b) The batterer is held accountable for acts of domestic violence.
  - (c) The program is at least 29 weeks in length and includes 24 weekly sessions, plus appropriate intake, assessment, and orientation programming.
  - (d) The program content is based on the below-listed psychoeducational model that addresses tactics of power and control by one person over another.  
Model Name or Description: \_\_\_\_\_
  - (e) The program is funded by a user fee in the amount of \_\_\_\_\_ paid by the batterers who attend the program, which allows them to take responsibility for their acts of violence. An exception is made for local, state, or federal programs that fund batterers' intervention programs in whole or in part.
8. The BIP Provider currently and will continue to satisfy all criteria for to be included on the list of batterer intervention programs, and that the BIP Provider should be included on the Court's list of providers.

9. I understand that the BIP Provider is responsible for continuously meeting the statutory requirements for batterer intervention programs.
10. The Court may audit the BIP Provider's program as necessary to ensure compliance with the Florida statutes. I understand that such audit may include a survey of participants of the BIP Provider's program. The BIP Provider will fully cooperate with any efforts to conduct such audit.
11. I understand that it is my responsibility to **IMMEDIATELY** notify the court if the BIP Provider no longer meets any of the statutory requirements. This notification must be sent to: \_\_\_\_\_ (name, contact info of TCA), at which time the BIP Provider's name will be immediately removed from the court's list of providers.
12. I further understand that failure to notify the court when the BIP Provider is no longer in compliance with the statute may constitute fraud for which I and/or the BIP Provider may be subject to liability.
13. I understand that if I no longer am employed by or represent the BIP Provider I or the BIP Provider must contact the courts immediately and the BIP Provider must issue an affidavit by the new legal representative of the BIP Provider in order to remain on the list of eligible providers.

**I DECLARE UNDER PENALTY OF PERJURY**, under the laws of the State of Florida, that the statements and facts indicated in this Affidavit are true and correct.

(Name) \_\_\_\_\_ (Date) \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

E-mail Address(es): \_\_\_\_\_

STATE OF FLORIDA  
 COUNTY OF \_\_\_\_\_

Sworn to or affirmed and signed before me on by

\_\_\_\_\_  
 NOTARY PUBLIC or DEPUTY CLERK  
*[Print, type, or stamp commissioned name of notary or deputy clerk]*  
 Personally known       Produced identification  
 Type of identification produced \_\_\_\_\_

Click to view: [MEMO Batterers Intervention Programs \(9-10-2015\)](#)