


**EMPLOYMENT REHABILITATION PROVIDER APPLICATION  
PURSUANT TO 39-A M.R.S.A. §217**

  
STATE OF MAINE  
WORKERS' COMPENSATION BOARD  
OFFICE OF MEDICAL/REHABILITATION SERVICES  
27 STATE HOUSE STATION  
AUGUSTA, MAINE 04333-0027

**Individual Provider's Name:** \_\_\_\_\_

**Individual Provider Email Address and Phone Number:**

\_\_\_\_\_  
Email Address Phone Number

**Mailing Address:** \_\_\_\_\_

\_\_\_\_\_  
City State Zip Code

**IF APPLICABLE:**

**Name of Business:** \_\_\_\_\_

**Business D/B/A:** \_\_\_\_\_

**Business Email Address and Phone Number:**

\_\_\_\_\_  
Email Address Phone Number

**Business Mailing Address:** \_\_\_\_\_

\_\_\_\_\_  
City State Zip Code

**SELECT TYPE OF APPLICATION SUBMISSION:**

- Initial Appointment
- Reappointment
- Update Or Change Information

## EMPLOYMENT REHABILITATION PROVIDER APPLICATION

### SELECT ALL QUALIFICATIONS THAT APPLY:

- Minimum of five years' experience in employment rehabilitation services.
- Certification as a Certified Rehabilitation Counselor (CRC).  
Certificate Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_
- Bachelor's degree in rehabilitation counseling.
- Bachelor's degree in a field closely related to rehabilitation counseling.  
Degree field: \_\_\_\_\_
- Master's degree in rehabilitation counseling.
- Master's degree in a field closely related to rehabilitation counseling.  
Degree field: \_\_\_\_\_

### MAKE SURE YOUR APPLICATION IS COMPLETE:

- An up-to-date résumé is attached;
- Legible copies of any active certifications and degrees are attached; and
- I have included at least one rehabilitation report written by the applicant. **ALL CONFIDENTIAL INFORMATION MUST BE REDACTED OR THE ENTIRE APPLICATION WILL BE REJECTED AND RETURNED.**

### **PLEASE READ AND SIGN BELOW:**

I hereby certify the foregoing information is truthful, accurate and complete. I agree to notify the Workers' Compensation Board if any changes occur that impact the information contained in this application.

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Signature

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Date

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Printed Name of Applicant

Please mail, fax or email application and all required documents to:  
Workers' Compensation Board  
Office of Medical/Rehabilitation Services  
27 State House Station  
Augusta, Maine 04333-0027  
Fax Number: 207-287-7198

If you have any questions about this application, please contact  
Lindsay Lizzotte at the Workers' Compensation Board  
Telephone Number: 207-287-7016  
[Lindsay.Lizzotte@maine.gov](mailto:Lindsay.Lizzotte@maine.gov)