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

☑ SELECT TYPE OF APPLICATION SUBMISSION: ☐ Initial Appointment ☐ Reappointment

Name: _____

Email Address:_____

Phone Number: _____

Name of Business (if applicable):_____

Mailing Address: _____

_____
City State Zip Code

☑ 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.

_____
Signature Date