

# R-20

## Application for Approval and Registration

Rehabilitation Consultant Intern

Please PRINT or TYPE

**PERSONAL DATA**

NAME (last, first, middle)		PROSPECTIVE EMPLOYER	
ADDRESS (residence)			
CITY	STATE	ZIP CODE	EMPLOYER ADDRESS
HOME PHONE NUMBER	BUSINESS PHONE NUMBER	CITY	STATE ZIP CODE

1. Do you hold a professional licensure, certification or registration?  Yes  No  
 If yes, which certification?  CRC  CDMS Other: \_\_\_\_\_  
 Please attach a copy of any license/certification/registration.
  
2. Name of Qualified Rehabilitation Consultant (QRC) under whose supervision you will work. \_\_\_\_\_
  
3. One hundred dollars (\$100.00) registration fee payable to the Commissioner of the Department of Labor and Industry.  
 (check if registration fee is attached)
  
4. Do you speak or write any foreign language?  Yes  No  
 If yes, name language and number of years. \_\_\_\_\_
  
5. Are you able to communicate with the deaf in sign language?  Yes  No
  
6. Have you applied for registration as a QRC/Intern or a Registered Rehabilitation Vendor in Minnesota in the past?  
 Yes  No If yes, give date(s) \_\_\_\_\_

**EDUCATION DATA**

**ATTACH OFFICIAL TRANSCRIPTS OF ALL PERTINENT POSTSECONDARY EDUCATION**

NAME OF SCHOOL	CITY/STATE	DATES ATTENDED		DEGREE OR HIGHEST GRADE COMPLETED
		FROM month/year	TO month/year	

Attach a list of continuing education within the past **2 months** which pertains to this registration.

**NOTE TO QRC SUPERVISOR:** Please see Minn. Rules 5220.1400, subp. 3a and attach a plan of supervision addressing all of the requirements of this subpart.

**EMPLOYMENT HISTORY**

Describe in DETAIL your work history beginning with your current or most recent job. Attach an additional sheet, if necessary.

EMPLOYER NAME	PHONE NUMBER	IMMEDIATE SUPERVISOR NAME
ADDRESS	DATES (from and to)	
CITY STATE ZIP CODE	JOB TITLE	

Duties:

EMPLOYER NAME	PHONE NUMBER	IMMEDIATE SUPERVISOR NAME
ADDRESS	DATES (from and to)	
CITY STATE ZIP CODE	JOB TITLE	

Duties:

List or attach any other information that may be pertinent to registration (i.e., honors, peer recognition, etc.)

I authorize the Workers' Compensation Division, Department of Labor and Industry to make any investigation of the application and supporting documents. I understand that any omission or misrepresentation may result in rejection or revocation of registration.

I hereby agree to be bound by all statutes, rules and orders and realize that violations may result in revocation of registration.

**Subject to approval of this application I agree to notify the Workers' Compensation Division, Department of Labor and Industry of any change in my employment status. Given a change in my employment status I will accept the responsibility to notify all parties to the case on which I am the assigned Qualified Rehabilitation Consultant as to whom the reassignment will be made, subject to approval of the Commissioner of Labor and Industry.**

**I CERTIFY THAT I AM A FULL-TIME RESIDENT OF MINNESOTA, or I live no more than 100 miles by road from the Minnesota border. (Minn. Rules 5220.1400, subp. 5)**

APPLICANT SIGNATURE	DATE
NOTARY FOR APPLICANT	MY COMMISSION EXPIRES

I hereby agree to provide the supervision outlined on the attached sheet and as provided by Minn. Rules 5220.1400, subp. 3a.

SUPERVISOR SIGNATURE	DATE
NOTARY FOR SUPERVISOR	MY COMMISSION EXPIRES

***This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5036 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.***