

Rhode Island Department of Labor & Training
Division of Workers' Compensation
249 Blackstone Boulevard
Providence, RI 02906-5899
(401) 243-1200 Fax (401) 222-3887



Do not write in this space

APPLICATION FOR CERTIFICATION AS
QUALIFIED REHABILITATION COUNSELOR OR
QUALIFIED REHABILITATION COUNSELOR INTERN

If your application is incomplete or any of the required verification is missing, your application will be returned to you. Before proceeding, please refer to the Rhode Island Division of Workers' Compensation Rules and Regulations of Rehabilitation Counselors.

1. Name _____
LAST FIRST MIDDLE INITIAL

2. Address _____
NUMBER STREET CITY STATE ZIP CODE

3. Home Telephone _____ Work Telephone _____

4. Date of Birth _____ Firm Name _____
MONTH DAY YEAR

E-Mail _____

5. I am making application for certification as a:

- Qualified Rehabilitation Counselor Qualified Rehabilitation Counselor Intern

6. I have previously applied to this office for certification Yes No

- As a Qualified Rehabilitation Counselor As a Qualified Rehabilitation Counselor Intern

If so, please indicate your identification number _____ Expiration Date: _____

7. Current certification(s) you hold:

- No. _____ Certified Rehabilitation Counselor
No. _____ Certified Insurance Rehabilitation Specialist
No. _____ Certified Vocational Evaluator
No. _____ Certified Case Manager
No. _____ Certified Disability Management Specialist

Evidence of certification must be submitted with this application. If you have one of these 4 certifications, you may proceed to number 13 on this application.

8. Current combination of work experience, education and certification that you hold:

- Certification as a CRRN and 1 year of directly relevant work-related disability rehabilitation experience.
- Master's degree in vocational rehabilitation or an allied social science and a minimum of 1 year of work experience in a vocational work-related disability rehabilitation.
- Vocational counselor in the State Division of Vocational Rehabilitation or the Dr. John E. Donley Rehabilitation Center.

Education and experience requirements for CRC, CIRS, CRRN, CVE, or CCM have been completed. Certifications applied for but not yet received.

Licensed Registered Nurse with 3-years of directly relevant experience in Industrial Rehabilitation.

9. Education:

Bachelor's Degree Yes No Degree received _____

College: _____ Date _____

Master's Degree Yes No Degree received _____

College: _____ Date _____

Other academic or professional certification programs:

Name _____

Dates attended _____

Certificate awarded _____

10. History of professional experience. List only those work experiences that meet the criteria of appropriate experience as defined by the R. I. Rules and Regulations for Rehabilitation Counselors. Start with your most recent experience.

Employer _____

Address _____

Dates of employment: from _____ to _____

Job Title _____ Supervisor _____

Number of hours worked weekly _____ Was this a paid position? Yes No

Work Activities	Frequency			
	0-5%	5-10%	10-20%	20% or more
Vocational assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Job Placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Case work, case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Develop and monitor medical services and care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Client assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administrative planning/supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rehabilitation coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physical or occupational therapy

Other

50% or more of the above employment was spent as a rehabilitation counselor providing rehabilitation services to a work related disabled population. Yes No

History of professional experience (continued)

Employer _____

Address _____

Dates of employment: from _____ to _____

Job Title _____ Supervisor _____

Number of hours worked weekly _____ Was this a paid position? Yes No

Frequency

Work Activities	0-5%	5-10%	10-20%	20% or more
Vocational assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Job Placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Case work, case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Develop and monitor medical services and care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Client assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administrative planning/supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rehabilitation coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical or occupational therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

50% or more of the above employment was spent as a rehabilitation counselor providing rehabilitation services to a work related disabled population. Yes No

The Director has my permission to contact the employers above, and I specifically consent to the release of information by them. Yes No

11. Verification of supervision for Qualified Rehabilitation Counselor Intern (QRCI) Certification

Supervisor's Q. R. C. Number _____

Supervisor's Name _____
LAST FIRST MIDDLE INITIAL

Supervisor's Firm _____

Firm Address _____
NUMBER STREET CITY STATE ZIP CODE

List the names of all other QRC Interns who are supervised by this Q. R. C.

12. The following plan outlines when I will obtain the credentials necessary to meet the criteria for QRC status.

I understand that if there is a change in my supervision status, I am required to promptly notify the Director when the change will occur and what new arrangement for supervision will exist.

13. I hereby certify and affirm that I have read and understand the information provided herein. I have read the Code of Ethics for Rehabilitation Counselors and agree to observe the tenets contained therein.

DATE

SIGNATURE

Subscribed and sworn before me this _____ day of _____, 20_____.

Notary Public

THE STATE OF RHODE ISLAND DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, RELIGION, NATIONAL ORIGIN, GENDER, AGE, HANDICAP OR MARITAL STATUS.