Maryland Workers' Compensation
Rehabilitation Service Practitioner Application Instructions

APPLICATION

1. **Applications are to be typed or printed legibly. All questions on the application must be answered. NO applications via email/attachment or FAX.**
2. **All documentation must be original, on the forms currently in use by the Commission and submitted as a complete application packet.**
3. **Application fee of $150.00 (check) must be attached to the application. Make the check payable to MCRSP Workers' Compensation Commission.**
4. **Submit applications with required documents to the address listed below.**

Instructions for Nurses, Physical Therapists, and Occupational Therapists

- **Submit only the application, application fee and copy of your board license.**
- **Nurses must obtain Workers' Compensation Medical Case Management (WCCM) status from the Maryland Board of Nursing prior to submitting an application to the Commission for registration.**

Do not submit a copy of your college transcript or personal reference forms- just a copy of your license.

Instructions for Vocational Rehabilitation Counselors and Evaluators

- **CRC, CDMS, and CVE status- Submit only the application, application fee, and copy of your national certification.**
- **Rehabilitation Counselors and Evaluators without a license or national certification must submit the application, application fee, college/university transcript, and two personal reference forms.(The personal reference form and others needed are on the webpage).**

Transcripts:

Please have your college send your official transcript(s) directly to you in a sealed envelope. Send your sealed official transcript(s), the application, personal reference forms, and the application fee to the Commission in ONE packet. Do not have the college or university mail the official transcript directly to the Commission. The official seal of the college or university is required on all official transcripts with the date the degree was awarded/conferred.

Mail to:

Workers' Compensation Commission
Attn: MCRSP, Support Services Division
10 East Baltimore Street
Baltimore MD 21202

MARYLAND WORKERS' COMPENSATION COMMISSION

REHABILITATION SERVICE PRACTITIONER REGISTRATION APPLICATION

INSTRUCTIONS: Submit the original of this application and a check or money order (Cash/credit cards are not accepted) in the amount of $150 payable to MCRSP, Workers' Compensation Commission. Mail to: Workers' Compensation Commission, Attn: MCRSP Support Services Division, 10 E. Baltimore Street, Baltimore MD 21202

PERSONAL INFORMATION

NAME: ______________________________ (__________________) ____

Last | Maiden | First | MI

BUSINESS ADDRESS: ____

Number | Street

____

City | State | Zip

HOME ADDRESS: ____

Number | Street | City | State | Zip

HOME PHONE: __________________ WORK PHONE: _________________ SSN ___________________

PROFESSIONAL INFORMATION:

1. Vocational Services Practitioners must identify the professional licensing or registration entity/agency.

License Type	Date Issued	License/Registration #	Expiration Date
______________________________	_____________	__________________	_____________
______________________________	_____________	__________________	_____________
______________________________	_____________	__________________	_____________

2. Healthcare practitioners must identify the Board or Commission issuing license or registration.

Healthcare Practitioner's Licensing Board or Commission	Date Issued	License/Registration #	Expiration Date
______________________________	______________	___________________	_____________
______________________________	______________	___________________	_____________

3. Have you ever been denied a license & or registration? [ ] Yes [ ] No. If you answered "Yes," please provide details including the licensing agency contact information:

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4. Have you ever had a license or a registration revoked, canceled, suspended, or investigated? [ ] Yes [ ] No. If you answered "Yes," please provide details including the licensing agency contact information:

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5. Are you currently registered in the Maryland Workers' Compensation Commission Vocational Rehabilitation Practitioner's Online Listing?

[ ] Yes Practitioner Registration Number: ___________________ [ ] No

ACADEMIC INFORMATION (No resumes accepted)
List Colleges or Universities attended beginning with the most recent and provide official transcripts.
Attach additional sheets, if necessary.

1. Name of School:______________________________

Location of School:______________________________
City State

Dates Attended:From:______________ ______ To:______________ ______
Mo. Yr. Mo. Yr.

Major Field of Study:______________ Date/Degree Granted:__________

2. Name of School:______________________________

Location of School:______________________________
City State

Dates Attended:From:______________ ______ To:______________ ______
Mo. Yr. Mo. Yr.

Major Field of Study:______________ Date/Degree Granted:__________

3. Name of School:______________________________

Location of School:______________________________
City State

Dates Attended:From:______________ ______ To:______________ ______
Mo. Yr. Mo. Yr.

Major Field of Study:______________ Date/Degree Granted:__________

4. Name of School:______________________________

Location of School:______________________________
City State

Dates Attended:From:______________ ______ To:______________ ______
Mo. Yr. Mo. Yr.

Major Field of Study:______________ Date/Degree Granted:__________

EMPLOYMENT INFORMATION – GENERAL
Describe in detail your work history, beginning with the most recent employment. List the specific duties and responsibilities for each position. The detailed employment information is important in evaluating your experience. Include additional information on an attached sheet as necessary. ANY CHANGE IN EMPLOYMENT MUST BE REPORTED TO THE COMMISSION IMMEDIATELY.

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1. Employer:____________________________________ Dates: From_________ To___________
Job Title:____ Phone: # ( )_____________________
Address:____
Name of Immediate Supervisor:__________________________________ Phone # ( )______
Duties/Responsibilities:____
____

2. Employer:____________________________________ Dates: From_________ To___________
Job Title:____ Phone: ( )_____________________
Address:____
Name of Immediate Supervisor:__________________________________ Phone # ( )______
Duties/Responsibilities:____
____

3. Employer:____________________________________ Dates: From_________ To___________
Job Title:____ Phone: ( )_____________________
Address:____
Name of Immediate Supervisor:__________________________________ Phone # ( )______
Duties/Responsibilities:____

EMPLOYMENT INFORMATION – REHABILITATION SERVICES
Number of years (whole) engaged in rehabilitation services: _____________________________________
Current Job Title: (CHECK ONLY ONE: Number codes are for office use only)

_______	Rehabilitation Counselor (1)	_______	Vocational Evaluator-not PT or OT (6)
_______	Supervisor (Rehabilitation Staff) (2)	_______	Full-time Student (7)
_______	Job Development/Placement (3)	_______	Physical Therapist (8)
_______	Medical Case Manager (4)	_______	Occupational Therapist (9)
_______	Rehab Educator/Counselor (5)	_______	Other (49) – Specify

Circle the primary area that you serve: (Select One Only)

Allegany	01-1	Dorchester	07-1	St. Mary's	05-3
Anne Arundel	03-1	Frederick	02-2	Somerset	07-2
B. City	03-2	Garrett	01-2	Talbot	06-5
Baltimore	03-3	Harford	03-4	Washington	01-3
Calvert	05-1	Howard	04-1	Wicomico	07-3
Caroline	06-1	Kent	06-3	Worcester	07-4
Carroll	02-1	Montgomery	04-2	Out-of-State	08
Cecil	06-2	Prince Georges	04-3	(name state) ______________________	
Charles	05-2	Queen Anne's	06-4		

PLEASE READ CAREFULLY

As an applicant for MCRSP registration, I acknowledge that the Workers' Compensation Statute requires all practitioners providing vocational rehabilitation services in the State of Maryland be registered by the Workers' Compensation Commission. I certify that the information on this application is true and accurate to the best of my knowledge, and I authorize the Workers' Compensation Commission to verify this information. I understand that any omission or misrepresentation of information may result in rejection of my application or suspension of registration, and that failure to be registered, either due to non-submission of an application for registration or rejection of application, will result in non-payment for rehabilitation services provided. I agree to abide by the rules and regulations of the Workers' Compensation Statute. I acknowledge that I have received the MCRSP rules and regulations and am familiar with the requirements of the statute. I understand that once registered by the Workers' Compensation Commission, I am required to renew my registration every three (3) years to meet registration renewal requirements. I understand that the issuance of MCRSP registration does not imply that the practitioner possesses the knowledge or skill or that they are suitable for employment. I understand that the issuance of the registration means that the practitioner has met the educational, experience, and supervisory requirements pursuant to COMAR LE§9-6A-09. I understand that I am required to inform the Workers' Compensation Commission of any changes in employment, address, and status of my registration through other issuing agencies immediately. I acknowledge that failure to comply with the above terms and the standards of practice may result in suspension of my registration status.

Signature:____ Date:______________

DO NOT WRITE BELOW THIS LINE

FOR COMMISSION USE ONLY

Date Application Received: ______________

M.O/Check #: __________________ Transcript Received: ______________

Approved: ___________ Date: _____________ Registration Mailed: ________________

Registration Number: ____________________________

Date Denied: _____________ Reason for Denial: ____

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