MARYLAND WORKERS' COMPENSATION COMMISSION

VOCATIONAL REHABILITATION PROVIDER ENROLLMENT APPLICATION

INSTRUCTIONS: Pursuant to COMAR 14.09.05.08 this form must be submitted to the Commission for enrollment as a Vocational Rehabilitation Provider Organization. Companies with subsidiaries and/or multiple office locations must submit a separate application for registration for each location. The location of the main branch office will be assigned a registration number for use by all branches. The Main Branch is responsible for providing information to all branches located out of state. Any changes in company name, address, contact person, and professional staff MUST be reported to the Vocational Rehabilitation Office of the Workers' Compensation Commission within ten business days on the application form, signed and dated by the contact person.

Provider Name: _____

Provider Address: _____
Street Suite/Room Number

_____
City County State Zip Code

Contact Person:_____ Position Title:_____

Telephone: _____ Ext. _____Fax number: _____ Email address:_____

TYPE(S) OF SERVICE(S) PROVIDED: (Check all appropriate fields)

☐ Vocational Counseling, Job Development and Placement ☐ Occupational Therapy ☐ Medical Case Management
☐ Work Hardening & Functional Capacities Assessment ☐ Telephonic Case Management ☐ Vocational Assessment and Evaluation

Current Number of Professional Staff: (Enter corresponding numbers in the Parenthesis)
(____) Vocational Counselors (____) Vocational Evaluators
(____) Nurse Case Managers/Medical Coordinators (____) Physical Therapists
(____) Telephonic Nurse Case Managers (____) Occupational Therapists

IMPORTANT INFORMATION:
Please attach a list of registered vocational rehabilitation practitioners currently providing services to Maryland disabled covered employees: **Counselor (CR) Evaluator (ER) Nurse Case Manager (NCM) Case Manager (CM) Telephonic Case Manager (TCM) Physical Therapist (PT) Occupational Therapist (OT)**

Practitioner Name	Registration #	Primary Professional Title (one only)

I certify that the foregoing information is true and accurate to the best of my knowledge and information.

Signature of Contact Person:_____ Date signed:_____

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