Minnesota Department of Labor and Industry
Financial Services
443 Lafayette Road North
St. Paul, MN 55155
(651) 284-5459 or
1-800-342-5354 (DIAL DLI)
www.dli.mn.gov

R-20

Application for Approval and Registration

Qualified Rehabilitation Consultant Intern

Please PRINT or TYPE

PERSONAL DATA

NAME (last, first, middle)		
ADDRESS (residence)		PROSPECTIVE EMPLOYER
CITY STATE ZIP CODE		EMPLOYER ADDRESS (Your mailing 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. Enclose a check or money order for $110.00 payable to the Commissioner of the Department of Labor and Industry. (This includes the 10% surcharge pursuant to 2009 Laws, Chapter 101, Article 2, Section 59.) Send all application documents and fees to the Department's Financial Services Section at the above address.
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 FROM month/year	DATES ATTENDED TO month/year	DEGREE OR HIGHEST GRADE COMPLETED

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 Intern 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) 284-5459 or 1-800-342-5354/Voice or TDD (651) 297-4198.