VERMONT

www.labor.vermont.gov

DEPARTMENT OF LABOR
WORKERS' COMPENSATION DIVISION
5 Green Mountain Drive, PO Box 488
Montpelier, VT 05601-0488
802-828-2286

DEPT. USE ONLY Rev. 11/13

Cert. No. _____
Date Issued _____
Date Renewed _____
Date Suspended _____

APPLICATION FOR VERMONT CERTIFICATION
as a VOCATIONAL REHABILITATION COUNSELOR or JOB DEVELOPER/INTERN

Please review the Vermont Department of Labor, Workers' Compensation Division, Rules and Regulations before proceeding.

1. *Name* _____
   Last *Maiden* *First* *Middle Initial*
2. *Address* _____
   Street *City* *State* *Zip Code*
3. *Home Phone No.* _____ *Work Phone No.* _____
4. *Date of Birth* _____ *Last 4 digits of Social Security Number:* _____
5. *E-mail Address:* _____
6. *Employer Name* _____
7. *Employer Address* _____
   Street *City* *State* *Zip Code*
8. *Employer Phone No.* _____
9. *List any Licensure or Certification you currently hold.*
   _____
10. *I am applying for certification as:* ☐ *Vocational Rehabilitation Counselor* ☐ *Vocational Rehabilitation Job Developer/Intern***
11. *I have previously applied to this office for certification as a* _____ *on* _____
12. *Have you ever been fined, convicted or charged for any violation of the law? If yes, please attach additional paper and describe fully.*
    ☐ *No* ☐ *Yes (Attach Additional Information)*

EDUCATION

Bachelor's Degree ☐ *Yes* ☐ *No* *Official transcript attached* ☐ *Yes* ☐ *No*

College _____ *Degree Received* _____

Master's Degree ☐ *Yes* ☐ *No* *Official transcript attached* ☐ *Yes* ☐ *No*

College _____ *Degree Received* _____

Other Academic or Professional Certification Programs

Name	*Dates Attended*	*Certificates Awarded*

HISTORY OF PROFESSIONAL EXPERIENCE

List only those work experiences that meet the criteria of appropriate experience as defined by the Vermont Department of Labor, Workers' Compensation Division, Rules and Regulations. Start with your most recent experience. **Attach a signed statement from employer (per Rule 57.1700).**

Employer _____

Address _____

Date of Employment: *From* _____ *To* _____
Month / Day / Year *Month / Day / Year*

Job Title _____ *Supervisor* _____

Number of hours worked weekly _____ *Paid position?* ☐ *Yes* ☐ *No*

Describe work activities (attach additional sheets if necessary):

Employer _____

Address _____

Date of Employment: *From* _____ *To* _____
Month / Day / Year *Month / Day / Year*

Job Title _____ *Supervisor* _____

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

Describe work activities (attach additional sheets if necessary):

The applicant, by signing this application, hereby attests:

(1) The Department of Labor is authorized to verify any information on this application. I understand that a misrepresentation may result in rejection of my application or revocation of my certification.

(2) I agree to promptly submit any information requested for registration or monitoring purposes.

(3) I agree to attend training sessions sponsored by the Department of Labor, Workers' Compensation Division, as required by the Rules.

Signed: _____ *Date:* _____

**For Vocational Rehabilitation Job Developer/Intern a signed statement from the vocational rehabilitation counselor that will be responsible for your work must be attached.