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

DEPT. USE ONLY Rev. 12/12

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 Social Security No.

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):

HISTORY OF PROFESSIONAL EXPERIENCE

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.