Workers' Compensation Division
Department of Consumer and Business Services

Vocational Assistance Certification Program
Individual Certification under OAR 436-120

Please print

Name: _____
(Last) (First) (Middle initial)

Mailing address*: _____

_____
(City) (State) (ZIP)

Phone: _____ _____ _____
(Work) (Home) (Fax)

SSN** (See notes at bottom of page.): _____ _____
(Email)

Requesting initial certification or renewal of certification for:

- ☐ Vocational rehabilitation counselor
- ☐ Vocational rehabilitation intern
- ☐ Return-to-work specialist

Provider information:

Individuals providing vocational assistance must be on the staff of a registered vocational assistance provider, insurer, or self-insured employer (OAR 436-120-0810).

Provider name: _____ Provider number, if known: _____

Contact name: _____

Credentials for initial certification or renewal under OAR 436-120-0810, 0820 (check all that apply)

☐ If you are using a professional certification to qualify or renew, attach the corresponding certification.

☐ If you are using continuing education units to renew, attach verification of the continuing education units completed within the five years before renewal.

☐ If you are using education and formal training to qualify, include a copy of your diploma or transcripts.

Number of credits included: _____

☐ If you are using work experience to qualify, describe the work experience that qualifies you for your certification. Attach additional pages, if necessary.

Employer: _____ Supervisor's name: _____

Address: _____ Phone no.: _____

Your title: _____

Specific duties:	% of time	Total time: _____ (years) (months) From: _____ (month) (year) To: _____ (month) (year) Average hours worked per week: _____

Notes:

***Under OAR 436-120-0810, certified individuals must notify the division within 30 days of any changes in address and telephone number.**

****As part of your application for an initial vocational certification by the Department of Consumer and Business Services, you must provide your Social Security number (SSN). This is mandatory under ORS 25.785. Failure to provide your SSN will be grounds for denial of request.**

Employer: _____ Supervisor's name: _____

Address: _____ Phone no.: _____

_____ Your title: _____

Specific duties:	% of time	Total time: _____ (years) (months) From: _____ (month) (year) To: _____ (month) (year) Average hours worked per week: _____

By my signature, I certify that all answers and statements on this application are true and complete to the best of my knowledge. I understand that supervisors may be contacted regarding my job duties. I understand that, should an investigation disclose untruthful or misleading answers, my application may be rejected, my name removed from consideration, or my certification withdrawn.

Signature: _____ Date: _____

For help with this form, contact the Employment Services Team at 503-947-7812 or 800-452-0288 (toll-free).

Send this completed form, as well as all required documents to:

Workers' Compensation Division
Employment Services Team
350 Winter St. NE
PO Box 14480
Salem, Oregon 97309-0405
Or, fax to 503-947-7581

Keep a copy of this form for your records.