

Request to be added to the NC Industrial Commission Registry of Worker's Compensation Rehabilitation Professionals

Please fill out the following information and submit to yolanda.newsome@ic.nc.gov or fax to 919-715-0282.

Date: _____

Rehabilitation Professional Full Name: _____

RN License Number and Expiration Date: _____

What state if not NC RN License: _____

Certification Type: ☐ CCM ☐ CRC ☐ CDMS ☐ CRRN ☐ COHN or COHN-S

☐ CVE ☐ ONC ☐ Not yet certified (IF NOT CERTIFIED, CERTIFICATION MUST BE OBTAINED WITHIN 2 YEARS.)

Certification Number and Expiration Date: _____

Years of Worker's Comp Experience: _____

Month/Year you began working NC Files: _____

Have you completed the **mandatory training** course, "Worker's Compensation Case Management in NC: A Basic Primer for Medical and Vocational Case Managers"? ☐ Yes ☐ No

If not, when are you registered to take the class? _____

Date of Course and Certificate Number, if completed: _____

Company Name: _____

Email Address: _____

Telephone Number: _____

***If you are not certified (CCM, CRC, CDMS, CRRN, COHN, CVE, or ONC) or do not have two years' worker's compensation experience, please fill out the following:**

Supervisor's Full Name: _____

Supervisor's RN License Number and Expiration Date: _____

What state if not NC RN License: _____

Certification Type: ☐ CCM ☐ CRC ☐ CDMS ☐ CRRN ☐ COHN or COHN-S

☐ CVE ☐ ONC

Supervisor's Certification Number and Expiration Date: _____

Date of NCIC Primer Course and Certificate Number: _____

Supervisor's Telephone Number: _____

Supervisor's Email Address: _____