Reset

Minnesota Department of Labor and Industry
Financial Services
443 Lafayette Road N.
St. Paul, MN 55155
www.dli.mn.gov

R-24

Qualified Rehabilitation Consultant Firm Application

(check one) ☐ **Initial registration**
☐ **Renewal** **Firm registration #** _____ **Expiration date** _____

Print in ink or type

Legal business name. Except for individuals and partnerships doing business under their own true full legal first and last name(s), **all businesses and assumed names (DBA) must be registered with the Office of the Secretary of State.**			
Business address (where certified mail can be delivered)			Contact person's name
City	State	ZIP code	Contact person's telephone number
Business telephone number			Contact person's email address

FOR INITIAL REGISTRATION APPLICATIONS ONLY

Have you previously applied for registration as a rehabilitation provider in Minnesota or any other state?

☐ Yes ☐ No

If yes, provide your registration number and identify the state if other than Minnesota: _____

Any data or information to support your application for registration as a qualified rehabilitation consultant (QRC) firm should be attached to this application. Examples include your resume, list of activities or license/certification information.

THE FOLLOWING INFORMATION IS REQUIRED FOR INITIAL REGISTRATION AND RENEWAL APPLICATIONS

Provide the following information for **ALL** management staff members, **which shall consist of at least one employee who is registered as a qualified rehabilitation consultant** (Minnesota Rules 5220.1600, subp. 1). Use additional sheet(s) if necessary. Attach resumes of those hired from outside your organization since last registration approval.		
Name	Job title	Email
Office address		Phone
Name	Job title	Email
Office address		Phone

Provide the following information for **ALL** non-management staff members. Use additional sheet(s) if necessary.		
Name	Job title	Email
Office address		Phone
Name	Job title	Email
Office address		Phone
Name	Job title	Email
Office address		Phone

THE FOLLOWING INFORMATION IS REQUIRED FOR INITIAL REGISTRATION AND RENEWAL APPLICATIONS

You must complete 1 or 2 below.

1 – Workers' compensation insurance policy information

Insurance company name (not the insurance agent)		Insurer's NAIC number
Policy number	Effective date	Expiration date

2 – Reason for exemption from workers' compensation insurance

If you have questions regarding the need to obtain workers' compensation coverage, including exemptions, call (651) 284-5032 or 1-800-342-5354.

☐ I have no employees (see Minnesota Statutes § 176.011, subd. 9, for the definition of an employee).

☐ I am self-insured for workers' compensation (attach a copy of the authorization to self-insure from the Minnesota Department of Commerce).

☐ I have employees but they are not covered by the workers' compensation law (see Minn. Stat. § 176.041 for a list of excluded employees). Explain why your employees are not covered:

_____

_____

_____

☐ Other: _____

Note: You must notify the department if there is any change to your workers' compensation insurance information or employee status.

Payment Information: Enclose a check or money order for $200 payable to the "Minnesota Department of Labor and Industry". Send all application documents and fees to the department's Financial Services unit at the address indicated on the front of this form.

I authorize the Workers' Compensation Division, Department of Labor and Industry, to make any appropriate investigation of the application and supporting documents. I understand that any omission or misrepresentation may result in rejection of this application or denial of registration.

I agree to be bound by all statutes, rules and orders as established by the commissioner and realize that violations may result in the denial or revocation of registration.

I understand that Minnesota Rules 5220.1250 prohibits any ownership or financial relationship of any kind between any registered rehabilitation vendor and qualified rehabilitation consultant firm, qualified rehabilitation consultant or qualified rehabilitation consultant intern.

I agree to notify the department within two weeks of the occurrence of any change in the employment status of staff who provide direct services to injured workers under a rehabilitation plan or of staff members who directly supervise those persons. Any branch office openings or closings, as well as any change in the firm address, telephone number or contact person, must be reported to the department within two weeks of the occurrence (Minn. Rules 5220.1600, subp. 1).

I certify that the information provided on this form is accurate and complete. If I am signing on behalf of a business, I certify that I am authorized to sign on behalf of the business.

Notice: The information you as an individual provide in this application will be used by Department of Labor and Industry (department) staff members who require the information to determine if you meet the department's registration/renewal requirements. Minnesota Statutes § 270C.72, subd. 4, requires you to provide your Social Security number and Minnesota tax identification number on this application. The other information is being requested for purposes of processing your application. With the exception of your Social Security number and Minnesota tax identification number, you are not legally required to supply the data requested on this application. However, failure to provide the requested information may delay the processing of your application or result in the denial of the same. The application data will be made part of the department's file for your registration/renewal. Except for your name and the address you designated to receive correspondence from the department, the information you provide on this application is private data while the application is pending. Once you are registered, the application data may become public except for your Social Security number and Minnesota tax identification number. However, disclosure of private or nonpublic information to others may occur as authorized or required by law, including but not limited to the Attorney General's Office, the Department of Revenue, the Court of Administrative Hearings, upon court order, and/or for the purpose of verification, state investigations and statistics.

Print applicant's name (must be owner, officer or manager)	Title	
Applicant's Social Security number	Minnesota tax ID number (if applicable)	
Applicant signature	Date	
Notary signature	Date	My commission expires

This form is located at www.dli.mn.gov. The form can be made available in different formats, such as audio, Braille or large print. To request, call 651-284-5032 or 800-342-5354.