MARYLAND BOARD OF NURSING
APPLICATION FOR INITIAL CERTIFICATION
WORKERS COMPENSATION CASE MANAGER

I hereby make application for certification as a Workers Compensation Case Manager in the State of Maryland in accordance with the Maryland Annotated Code, Health Occupations Article, Section 8-205 and the Regulations Governing the Practice of a Workers Compensation Case Manager (10.27.16) and submit the following evidence of my qualifications for certification.

1. Personal Information — Fee: Twenty-Five Dollars ($25.00)

Name _____
(Last) (First) (Middle or Maiden)

Address _____
(Number and Street)

_____
(City) (State) (Zip Code)

Home Phone _____ RN Lic. # _____

Date of Birth _____ Social Security #: _____

2. Workers Compensation Medical Case Manager Education Program

_____
(Name of Education Provider)

_____
(Address)

Course length in hours _____ Date completed _____

3. Certification by Waiver (to be completed by the employer):

As the employer of the above individual, I affirm the licensee has been practicing as a registered nurse case manager with the injured worker prior to the effective date of the regulations(August 2, 1999.)

Employer _____ _____
Name Address

_____ _____
Telephone Number City, State, Zip code

4. Signature of licensee:

I affirm that the contents of this document are true and correct to the best of my knowledge and belief. I acknowledge that providing false or misleading information may result in disciplinary action by the Board.

_____ _____
Signature (Required) Date