DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

REQUEST FOR CERTIFICATION

P.O. Box 58
Jefferson City, MO 65102-0058
573-751-4231
labor.mo.gov/DWC

Completion of this form indicates that the rehabilitation provider is interested in being contacted by the Division regarding certification.

General Information:

Facility Name: _____

Address: _____

_____

******* For multi-site facilities, please attach a list of all locations.***

Contact Person: _____

Phone: _____ Fax: _____

Email: _____

Medical Director: _____ Years of Experience: _____

Date Facility Established: _____ Type of Facility: ☐ Inpatient ☐ Outpatient

List date of latest certification *(if applicable)*:

JCAHO _____ CARF _____ Medicare _____ Other *(specify)* _____

Has facility ever been certified by the Division? ☐ Yes ☐ No If Yes, please provide date: _____

What percentage of your client base is workers' compensation? _____

_____
Signature of person completing form

_____ _____
Title *Date*

Return completed form to:

Fax: 573-751-3721

Phone: 573-526-4945

Mail: Attn: Physical Rehabilitation
Missouri Division of Workers' Compensation
P. O. Box 58
Jefferson City, MO 65102-0058