



**Application for License to Employ Physically or Mentally Disabled or Those Impaired
by Age At Less Than the Illinois Minimum Wage**

IL DEPARTMENT OF LABOR
Fair Labor Standards Division – Licensing Section
160 North LaSalle, Suite C-1300
Chicago, IL 60601-3150
Tel # (312) 793-2804 - Fax #: (312) 814-1210

APPLICANT TYPE: (check one):	<input type="checkbox"/> Sheltered Workshop	<input type="checkbox"/> Regular Employer for Sub-Minimum Wage
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EMPLOYER INFORMATION

Name of Establishment:			
Address:			
City:	State:	Zip Code:	
Type of Business:			
Number of disabled workers in establishment:			
Total number of employees in establishment:			
Are meals or lodging furnished the disabled employees in addition to wages paid?	Yes	No	
If yes, give number furnished per day:	Meals:	Lodging:	
For verification, contact:	Telephone Number:		

EMPLOYEE INFORMATION

Employee Name:			
Address:			
City:	State:	Zip Code:	
Date of Birth:	Social Security #:		
Telephone #:	Employment Date:		
Duties of Employee:			
Nature of Disability:			
Apparent Degree of Disability in Performing Duties:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Grade Achievement:			
Education Level:			
Special Training:			
Skills:			

For verification, contact:		Telephone Number:
EMPLOYEE EMPLOYMENT AND TRAINING RECORD		
Previous employment pertinent to present situation:		
Proposed Wage (based on (disability and performance):	\$	per hour unit
Is it anticipated that performance may reach normal production standards?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, provide estimated period for which sub-minimum wage is requested (Request can not exceed two years):	months	weeks

CERTIFICATION FOR EMPLOYEE	
When the nature of the disability is due to mental disability, the legal guardian of the employee may act in behalf of the employee with respect to the acknowledgment of the disability and the acceptance of the modified minimum wage rate.	
Signature of employee indicating willingness to accept modified rate, subject to approval by the Director of Labor.	
_____	_____
Signature	Date

CERTIFICATION BY EMPLOYER OR AUTHORIZED REPRESENTATIVE	
I certify in applying for this certificate, that all foregoing statements are, to the best of my knowledge and belief, true and correct.	
_____	_____
Printed Name of Employer or Representative	Title
_____	_____
Signature of Employer	Date

LICENSE TO EMPLOY HANDICAPPED AT A SUB-MINIMUM WAGE RATE	
License is hereby granted to employ the above referenced handicapped employee at the wage specified and in accordance with the stated conditions.	
_____	_____
Director, Department of Labor	Date

FOR DEPARTMENT OF LABOR USE ONLY		
_____	<input type="checkbox"/> Approved	File#:
DOL Employee Signature	<input type="checkbox"/> Denied	
		Effective Date:
		Expiration Date:

NOTES: