

**APPLICATION FOR SUB-MINIMUM WAGE FOR
INDIVIDUALS WITH DISABILITIES**

NORTH DAKOTA DEPARTMENT OF LABOR

SFN 51371 (Rev. 05-2003)

Return completed application to:

North Dakota Department of Labor
State Capitol
600 E Boulevard Ave Dept 406
Bismarck ND 58505-0340
(701) 328-2660
1-800-582-8032
FAX 328-2031

Is this application for a(n) Initial certificate? Renewal certificate?

34-06-15 NDCC **Special license to employ at less than minimum wage.** The commissioner may issue to an employee whose productive capacity for the work to be performed is impaired by physical or mental disability, or to any student or learner enrolled in a vocational education or related program, a special license authorizing the employment of that licensee at less than the minimum wage. The commissioner may also issue special licenses to community rehabilitation programs for the handicapped which engage in the occupation and responsibility of representing and placing for the purpose of training, learning, or employment of those employees whose productive capacity for the work to be performed is impaired by physical or mental disability. The commissioner shall issue such licenses under rules adopted by the commissioner.

TO BE COMPLETED BY EMPLOYEE

Name of Employee		Date of Birth		Social Security Number
Address of Employee	City	State	Zip Code	Telephone Number
I have read the statements in this application and ask that the requested certificates be granted.				
<u> X </u>		_____		_____
Signature of Applicant				Date

TO BE COMPLETED BY EMPLOYER

		City	State	Zip Code	Telephone Number
Employer's Type of Business		How long has the worker been employed by the firm?			
		How long at present job?			
Job description of the employee's position (describe in detail). Continue on separate sheet, if necessary.					
Job Title					
Amount other employees are paid for this position			Amount employer proposes employee be paid		
\$ _____ Per _____			\$ _____ Per _____		
Reason for arriving at this amount? (Be specific and describe exactly what affects the employee's productivity and to what percentage in relation to an average worker.) Has a time study to determine the commensurate wage for the applicant been completed? Has a copy been enclosed? Continue on separate sheet, if necessary.					
I certify that, to the best of my knowledge and belief, all statements are true and accurate.					
<u> X </u>		_____		_____	
Signature of Employer or Authorized Official				Date	

TO BE COMPLETED BY PHYSICIAN

This report is requested in connection with an application for a certificate authorizing the employment of the individual named in this application at a subminimum wage under North Dakota Century Code 34-06-15. A certificate will be granted only if the disability is handicapping for the work performed. Only a licensed physician may complete this section. **The North Dakota Department of Labor does not pay for this examination.**

If other sufficient evidence exists it can be sent in place of Physician's authorization. Example: Information in a student's IEP or IHP.

Nature of Applicant's Disability:

- | | | |
|---|------------------------------------|--|
| <input type="checkbox"/> Mentally Retarded/Developmentally Disabled (MR/DD) | <input type="checkbox"/> Blindness | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Mental Illness (ME) | <input type="checkbox"/> Age | <input type="checkbox"/> Loss of Limb |
| <input type="checkbox"/> Other (specify) _____ | | |

What is the prognosis?

How and to what extent does the disability affect the applicant's ability to perform the type of work listed on the previous page?

Physician's Name	Address of Clinic		
Name of Clinic	City	State	Zip Code
Telephone Number	Date		

I verify that the above named patient has a disability that affects the individual's earning or productive capacity.

X

Signature of Physician