APPLICATION FOR SUB-MINIMUM WAGE FOR INDIVIDUALS WITH DISABILITIES

NORTH DAKOTA DEPARTMENT OF LABOR AND HUMAN RIGHTS

SFN 51371 (Rev. 10-2013)

Return completed application to:

600 E Boulevard Ave Dept 406
Bismarck ND 58505-0340
701-328-2660 Fax 701-328-2031
ND Toll-Free 1-800-582-8032
TTY: 1-800-366-6888
www.nd.gov/labor

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 eduction 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	Telephone Number	
Address of Employee	City	State	ZIP Code

I have read the statements in this application and ask that the requested certificates be granted.

X _____ _____

Signature of Applicant | Date

TO BE COMPLETED BY EMPLOYER

Name of Employer		Telephone Number	
Address of Employer	City	State	ZIP Code
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.

X _____ _____

Signature of Employer or Authorized Official | Date

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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 and Human Rights 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:

- ☐ Mentally Retarded/Developmentally Disabled (MR/DD)
- ☐ Blindness
- ☐ Physical Disability
- ☐ Mental Illness (ME)
- ☐ Age
- ☐ Loss of Limb
- ☐ 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