



**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):  Sheltered Workshop  Regular Employer for Sub-Minimum Wage

**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? |                   |           | <input type="checkbox"/> Yes <input type="checkbox"/><br>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,<br>contact:   |                              | Telephone Number:           |
| <b>EMPLOYEE EMPLOYMENT AND TRAINING RECORD</b>  |                              |                             |
| 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                       |

|  |       |
|--|-------|
| <b>CERTIFICATION FOR EMPLOYEE</b>  |       |
| 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  |

|  |       |
|--|-------|
| <b>CERTIFICATION BY EMPLOYER OR AUTHORIZED REPRESENTATIVE</b>  |       |
| 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  |

|   |       |
|---|-------|
| <b>LICENSE TO EMPLOY HANDICAPPED AT A SUB-MINIMUM WAGE RATE</b>   |       |
| 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  |

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

NOTES: