

Return Application To:
 DLSE Licensing
 1515 Clay Street, Suite 1902
 Oakland, CA 94612

State of California
 Department Of Industrial Relations
 DIVISION OF LABOR STANDARDS ENFORCEMENT



APPLICATION FOR SPECIAL MINIMUM WAGE LICENSE (Labor Code section 1191)

Application is hereby jointly made for a license to pay a special minimum wage to an individual under the provisions of Section 1191 of the Labor Code and Section 6 of the applicable Industrial Welfare Commission Order. **PLEASE CAREFULLY READ THE ACCOMPANYING GENERAL INFORMATION AND INSTRUCTIONS (DLSE 117-A) PRIOR TO COMPLETING THIS APPLICATION.**

<p>Establishment employing worker with a disability:</p> <p>1. Name _____</p> <p>Street Address: _____</p> <p>City: _____ County: _____ State: _____ ZIP Code: _____</p> <p>Mailing Address (If Different than Street Address): _____</p> <p>City: _____ County: _____ State: _____ ZIP Code: _____</p> <p>Contact Person/Telephone: _____</p> <p>Type of Business _____ IWC Order No. _____</p> <p>Federal Employer ID No. (FEIN): _____ State Employer ID No. (SEIN): _____</p>	<p>1a. Certified by U.S. Department of Labor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, Certificate No. _____ Exp. Date : _____ (Provide a copy)</p> <p>If No, on a separate page, provide an explanation of reason for no certification</p>
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<p>Worker with a Disability:</p> <p>2. Name _____</p> <p>Street Address: _____</p> <p>City: _____ State: _____ ZIP Code: _____</p>	<p>If legally conserved, Parent/Legal Guardian:</p> <p>3. Name: _____</p> <p>Street Address: _____</p> <p>City: _____ State: _____ ZIP Code: _____</p> <p>Telephone: (_____) _____</p>
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<p>Referring Organization:</p> <p>4. Name _____</p> <p>Street Address: _____</p> <p>City: _____ County: _____ State: _____ ZIP Code: _____</p> <p>Mailing Address (If Different than Street Address): _____</p> <p>City: _____ County: _____ State: _____ ZIP Code: _____</p> <p>Contact Person/Telephone: _____</p> <p>Status: <input type="checkbox"/> Public <input type="checkbox"/> Private, For Profit <input type="checkbox"/> Private, Not For Profit <input type="checkbox"/> Other _____</p>	<p>4a. Certified by U.S. Department of Labor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, Certificate No. _____ Exp. Date : _____ (Provide a copy)</p> <p>If No, on a separate page, provide an explanation of reason for no certification</p>
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5. Applicable primary program:

6. Status of Establishment Listed in No. 1, above: (Check One):

Public (State or Local Government) Private, For Profit Private, Not For Profit Other _____

If you checked Public, **STOP** - you do not have to complete this application - See General Information and Instructions

7. This is an application for New License Renewal License

See General Information and Instructions (DLSE 117-A) for information required to be listed on separate sheet

Proposed wage rate: \$ _____ per _____ (hour/day/week/month) for _____ hours per day/ _____ days per week

Plus _____ (specify meals, lodging, other items)

If renewal, wage rate paid during period covered by previous license: _____

If renewal, and wage rate is lower than previous license period, provide explanation and justification for lower wage rate. (Attach separate sheet if necessary). **You must also attach copies of documentation that evidences the justification for lower wage rate, including work measurement documentation.**

8. Will individual work at locations other than the above address? Yes No
If yes, see General Information and Instructions (DLSE 117-A) for information required to be listed on separate sheet

9. Has certification/accreditation to operate issued to the establishment and/or referring organization listed in No. 1 and/or 3 ever been denied, suspended or revoked by any certifying/accrediting agency? Yes No
 If yes, explain circumstances (Attach a separate sheet if necessary)

10. Does establishment listed in No. 1 above have current workers' compensation insurance coverage? Yes No
(Provide evidence of current coverage)
 Name of Insurer: _____ Policy Number _____
 Address: _____ Expiration Date: _____

11. Nature of disability which impairs applicant's earning capacity:

Mental Illness Visual Impairment Hearing Impairment Age Related
 Alcoholism Drug Addictions Neuromuscular General - No Primary Group
 Developmental Disability Specify: _____ Other Specify: _____

12. Describe work measurement method and evaluation process, including detailed description of work to be performed. (Attach a separate sheet if necessary) **You must also attach copies of work measurement documentation evidencing justification for wage rate being requested (See General Information and Instructions (DLSE 117-A) for instructions regarding required information/documentation)**

13. Date of last wage review _____ 14. Date of last prevailing wage survey _____

CERTIFICATION

I certify that I have read this form and to the best of my knowledge and belief, all answers and information given in the application and attachments and the representations set forth in support of this application to obtain or continue authorization to pay workers with disabilities at special minimum wage rates are true. I further represent that I have been notified of my rights and request that the license to be paid at a special minimum wage rate be issued.

 Individual's printed name Individual's signature Date

 If applicable, Parent/Guardian's printed name If applicable, Parent/Guardian's signature Date

CERTIFICATION

I certify that I have read this form and to the best of my knowledge and belief, all answers and information given in the application and attachments and the representations set forth in support of this application to obtain or continue authorization to pay workers with disabilities at special minimum wage rates are true. I further represent that the following terms and conditions exist (or will exist for initial applicants):

- (a) workers employed (or who will be employed) under the authority of Labor Code §1191 have disabilities for the work to be performed;
- (b) wage rates paid (or which will be paid) to workers with disabilities under the authority of Labor Code §1191 are commensurate with those paid experienced workers, who do not have disabilities, in industry in the vicinity for essentially the same type, quality and quantity of work;
- (c) the operations are (or will be) in compliance with the applicable Industrial Welfare Commission Order, the California Labor Code and all applicable State and Federal Law;
- (d) records will be maintained as required by Section 7 of the Industrial Welfare Commission Orders and consistent with the requirements of 29 CFR 525 including documentation of disability, productivity, work measurements and prevailing wage surveys;
- (e) a copy of the license shall be maintained at each location where individuals are employed;
- (f) a copy of the DOL poster "Employee Rights for Workers with Disabilities Paid At Special Minimum Wages" shall be posted at each location where individuals will be employed
- (g) consistent with the requirements of DOL, a wage review must be completed at least once every six months and a prevailing wage survey must be performed annually;
- (h) consistent with the requirements of Cal/OSHA an Injury and Illness Prevention Program (IIPP) shall be maintained along with all required Cal/OSHA documentation and reports; and
- (i) written and oral advice of wage rate being paid has been provided to each worker and/or his/her guardian.

 Print Name Title Date

 Signature