Application for Special Industrial Homeworker's Certificate

U.S. Department of Labor
Employment Standards Administration

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.	OMB No.: 1215-0005 Expires: 12-31-2007

INSTRUCTIONS:
Completion of Form WH-2 is necessary to obtain certificates to employ individual homeworkers in one of the restricted homework industries noted in item 1. below. The information collected is utilized by the Department to determine whether terms and conditions necessary to issue an individual certificate have been met. This is an application form only and not a certificate. Prepare three copies of this form and forward the original to this office. The duplicate is to be kept by the employer and the other copy given to the employee. All questions must be answered in full. The homeworker is to furnish information for Section 1. The employer furnishes information for Section 11. The signature of each is required on the application. Section III, Report of medical Examination, should be completed by a licensed physician.

This report is authorized by Section 11 (d) of the Fair Labor Standards Act. Completion of the form is voluntary. However, failure to provide the information will result in non-issuance of a homeworker certificate and such employment will be in violation of Section 11 (d) of the Fair Labor Standards Act. (See 29 CFR 530)

Section 1. Information To Be Furnished By Homeworker

1. Certificate is requested for employment in the industry checked below:

☐ Button & Buckle Manufacturing ☐ Gloves and Mittens ☐ Jewelry Manufacturing ☐ Women's Apparel

☐ Embroideries ☐ Handkerchief Manufacturing ☐ Knitted Outerwear

2. Name (Please print)	3. Address (Street No., Apt. No., if any)	
4. City or Town, State, ZIP Code	5. Age	6. Telephone Number (include Area Code) ( )

7. Explain fully why you are unable to work in a factory:

8a. Do you hold a State Homeworker Certificate?	b. If "Yes", name State	c. Expiration date of State Certificate

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

Signature of homeworker (if worker cannot write, signature may be made by mark (X) and witnessed by another person)

Signature or mark (X) of homeworker:

Signature of witness (if necessary):

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and -completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Administrator, Wage and Hour Division, Room S-3502, 200 -Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Section II. Information to be Furnished by Employer

9. Name and Address, including Zip Code of Employer	10. Name of State Vocational Rehabilitation Agency, If Any, Supervising Homeworker's Employment.
11. If work is to be distributed to homeworker from other than above address, enter name and address of firm or individual distributing work.	

I certify that the answers to the above questions are true and correct.

(Print or type name of employer or authorized representative)

(Telephone Number - including Area Code)

(Title)

(Signature of employer or authorized representative)

(Date)

Section III. Report of Medical Examination

12. Name of person examined:

Nature of disability:

A	**Application to work at home because of inability to work In a factory due to physical disability.** How and to what extent does the disability affect the ability of the applicant to undertake work in a factory?
B	**Application to work at home due to need to care for an invalid**. Does the disability of the invalid warrant care to the extent of prohibiting employment of the applicant away from home? ☐ Yes ☐ No. If "Yes", explain nature and extent of care required.

13. What is the prognosis?

14. Name and address, including ZIP Code, of examining physician (Print or type).	15. Physician's signature
	16. Date