

Application for Dispensation - Processors of Fruits and Vegetables

Complete this application and return it to the address above. Submit a separate application for each plant. Use additional sheets if needed.

1. Name of Establishment: _____
2. Address of main office: _____ City, town or village: _____
County: _____ State: _____ Zip: _____
Phone Number: (____) ____ - _____
3. Address of plant applied for: _____ City, town or village: _____
County: _____ State: _____ Zip: _____
4. Products to be processed during period:

5. 7-day request for employees 18 years of age and over
 - a. Maximum number of 7-day weeks per month requested: _____
 - b. Maximum number of employees to be affected by 7-day week dispensation: _____
 - c. Request 7 days without posting day of rest schedule? Yes No
 - d. Period for which dispensation is requested from: ____ / ____ / ____ to ____ / ____ / ____
6. The Defense Emergency Act provides that no dispensation shall be granted to any employer "who can by utilization of available labor supply or by organizational or other reasonable adjustments maintain maximum efficiency and production without such dispensation". What steps have you taken to maintain efficiency and production by better utilization of available labor supply or by other adjustments?

7. No permit can be issued unless the required Workers' Compensation Insurance and Disability Insurance documents (see below) are received.

You must provide proof of Workers' Compensation and Disability Insurance coverage. Acceptable proof includes:

- **From your insurance company**, a completed C-105.2 proving Workers' Compensation Insurance coverage is currently in effect, and a completed DB-120.1 proving Disability Insurance coverage is currently in effect
- A completed form U-26.3 from the New York State Insurance Fund showing that your Workers' Compensation Insurance coverage is currently in effect
- If you are self insured, provide a completed SI-12 or GSI-105.2 for Workers' Compensation Insurance coverage and a completed DB-155 for Disability Insurance coverage
- If you are insured by the New York State Insurance Fund, you may call toll free 888-875-5790 to request form U-26.3 and 866-697-4332 to request form DB-120.1

If you are **not** liable for WC and/or Disability Insurance, provide a completed CE-200 to this office. This form can be obtained on-line at www.wcb.ny.gov. On the home page, click on "WC/DB Exemptions" then click on "Request for WC/DB Exemption". You may contact the Workers' Compensation Board at 866-298-7830 for assistance in obtaining this form. When you call, wait until the menu finishes for someone to give you assistance.

I hereby certify that the above statements are true and accurate. I further certify that the establishment making this application carries Workers' Compensation insurance and/or Disability insurance if required.

8. Signature of Employer or Agency Officer: _____
9. Position or Title: _____
10. Date: ____ / ____ / ____