Iowa Division of Labor
Asbestos Abatement
1000 East Grand Avenue
Des Moines, IA 50319
Phone: 515-281-6175
Fax: 515-281-7995
Email: asbestos@iwd.iowa.gov
www.iowadivisionoflabor.gov/asbestos-abatement

FOR OFFICE USE ONLY
Date Received: _____
☐ Approved ☐ Denied

Physician's Certification

Instructions

Return the original completed form with an application for contractor/supervisor or worker asbestos license to the Iowa Division of Labor at the above address. The medical questionnaire from 29 CFR 1926.1101, Appendix D, is for the use of the physician and is not to be returned to the Iowa Division of Labor. The accuracy of this certification may be verified by the Iowa Division of Labor. Falsification of a physician's signature or other attempts to fraudulently obtain an asbestos license may result in criminal charges, denial of your application, forfeiture of your application fee, denial of any future applications for asbestos licenses and a civil penalty of up to $5,000.00

Applicant's full name	Date of birth

Physician Information

Name	Clinic name		
Address	City	State	Zip
Phone number	Fax number		

I certify that I have performed a physical examination of the above applicant on the date indicated. I have read the mandatory OSHA guidelines for this physical in 29 CFR 1910.134 and 1926.1101 and the examination I conducted was in accordance with the OSHA guidelines. I performed a physical examination of the applicant focused on the pulmonary and gastrointestinal systems, including tests of forced vital capacity and forced expiratory volume at one second. I interpreted and classified the applicant's chest in accordance with 29 CFR 1926.1101, Appendix E. The applicant was informed of the result of the examination and of any medical conditions which require further explanation or treatment. The applicant was informed of the increased risk of lung cancer attributed to the combined effects of smoking and asbestos exposure. I have determined that the applicant is capable of working while wearing a negative pressure respirator without restriction.

I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Physician's Signature **Date** **License Number** **Date of Exam**

STATE OF _____ **COUNTY OF** _____

Signed and sworn to (or affirmed) before me on this _____ **day of** _____ **, 20**__**,by** _____.
(name of physician)

_____

NOTARY PUBLIC in and for the State of _____

My commission expires _____