Iowa Department of Inspections, Appeals & Licensing
Asbestos Abatement
6200 Park Ave., Suite 100
Des Moines, IA 50321
Phone: 515-281-6175
asbestos@iwd.iowa.gov
asbestos.iowa.gov

Medical Certification

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

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. **A photocopy will not be accepted.** The medical questionnaire from 29 CFR 1926.1101, Appendix D, is for the use of the physician/physician assistant 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 or physician assistant'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 or Physician Assistant 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 or Physician Assistant's Signature **Date** **License Number** **Date of Exam**