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: _____
Asbestos License #: _____
☐ Approved ☐ Denied

Respirator Fit Test Form

This form must be submitted with a contractor/supervisor or worker asbestos license application. Send the original signed forms to the address above. A photocopy will not be accepted. The accuracy of this document may be verified by the Iowa Division of Labor. Falsification of any part of this form may result in criminal charges, denial of application, forfeiture of application fee, denial of future application and a civil penalty up to $5,000.00.

Print Legibly

Applicant Information

Name	Date of birth	Phone number

Respirator Information

Respirator name	Respirator model number
Respirator type	Respirator size

Fit Tester Information

Name	Company	Phone number	
Address	City	State	Zip
Fit test method used			

I certify that the above applicant has been successfully fit tested and is able to wear the above respirator. I certify that I am familiar with the OSHA procedures for fit tests found in 29 CFR 1926.1101, Appendix C, and followed those procedures while performing this fit test. I certify that the information on this form is true and accurate to the best of my knowledge.

Fit Tester Signature Date

Iowa Division of Labor
Asbestos Abatement
1000 East Grand Avenue
Des Moines, IA 50319
Phone: 515-281-6175
Fax: 515-725-2427
Email: asbestos@iwd.iowa.gov
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FOR OFFICE USE ONLY
License #:
Expiration date:
Check #:
Date entered:

Asbestos License Application

☐ New ☐ Renewal ☐ Replacement Previous Asbestos License #: _____

Instructions: Applicants must include non-refundable license fees payable to the Iowa Division of Labor and copies of training certificates. Email a head-and-shoulder picture of applicant to: asbestos@iwd.iowa.gov. Applicants for worker and contractor/supervisor license must also complete and return the original Respirator Fit Test and original notarized Physician's Certification forms.

License Type (more than one may be requested):

☐ Worker - $20.00 ☐ Inspector - $20.00 ☐ Contractor/Supervisor - $50.00

☐ Project Designer - $50.00 ☐ Management Planner - $20.00 ☐ Replacement Card - $10.00

Full applicant name			Date of birth	Social security #
Address		City	State	Zip
Phone number	Email	Contact person if different than applicant		Phone number

Notice: The Iowa Division of Labor may deny this application, or revoke or suspend your license if you knowingly make a false or fraudulent statement on this application or the attached documents. Criminal charges, forfeiture of your application fee, denial of future applications and a civil penalty of up to $5,000.00 may also result from obtaining or attempting to obtain a license through deceptive or fraudulent means.

Iowa Code Chapters 252J, 261 and 272D require records of asbestos licenses to be maintained by social security number. If you withhold your social security number, this application will be denied. Your social security number, name and address may be shared with other state agencies. If you are behind in payments to other agencies, this or future applications may be denied. If you have a license it may be suspended or revoked.

Certification and Authorization: I hereby certify the information I am submitting is true and valid and I am at least 18 years of age. I hereby authorize my physician to release to the Iowa Division of Labor information about the physical examination described in the attached Physician's Certification, if applicable.

☐ Mail the license to my address above (do not complete the box below)

☐ Mail the license to someone other than myself (compete the box below)

_____

Applicant Signature Date

Complete bottom portion ONLY if license is to be mailed to someone other than licensee

Permittee Acknowledgement

Company name	Your name	Title	Phone number	
Address	City		State	Zip

The permittee agrees to promptly deliver the license to the licensee.

_____

Authorized Signature Date

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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 _____