# TEXAS DEPARTMENT OF LICENSING & REGULATION

P.O. Box 12157 • Austin, Texas 78711-2157

*www.tdlr.texas.gov*

## LASER HAIR REMOVAL FACILITY CERTIFICATE OF REGISTRATION RENEWAL APPLICATION INSTRUCTIONS

DOCUMENTS SUBMITTED WITH YOUR APPLICATION WILL NOT BE RETURNED. KEEP A COPY OF YOUR COMPLETED APPLICATION, ALL ATTACHMENTS, AND YOUR CHECK OR MONEY ORDER.

1. FACILITY NAME – Full legal name of business.
2. DOING BUSINESS AS (DBA) NAME – Write the full DBA name for your business.
3. CERTIFICATE NUMBER – Enter your current license number.
4. EMAIL ADDRESS – By providing my email address I authorize TDLR to send licensing communications and required notices to me by electronic mail. I understand that I may revoke this authorization in writing and that I must update my email address or I will not receive these notices. I understand that the email address I have provided in this application will remain confidential except as permitted or required by law.
5. FACILITY PHONE NUMBER – Write a telephone number, including the area code, where we can reach you during the day. This may be your office phone number where we can leave a message.
6. FACILITY MAILING ADDRESS – Write your current mailing address. This is the address where we will send you mail. This address can be a post office box. You can add the zip plus-4 to help the postal service deliver mail more efficiently and accurately.
7. FACILITY PHYSICAL ADDRESS – Write the physical address of your facility. A post office box cannot be used for this address.
8. LASER HAIR REMOVAL(LHR) PROFESSIONAL – List the name of the individual that is designated as the facility LHR Professional along with their information and their LHR Professional certificate number.
9. LASER SAFETY OFFICER (LSO) – List the name of the individual that is designated as the LSO for the facility along with their laser hair removal (LHR) certificate number or physician license number (if applicable).
10. CONSULTING PHYSICAN INFORMATION – Write the consulting physician's name, license number, and phone number. Submission of email is optional (see item 4 for email disclosure information).
11. DESIGNATED PHYSICIAN INFORMATION – Write the designated physician's name, license number, and phone number. Submission of email is optional (see item 4 for email disclosure information).
12. **IMPORTANT: You must submit a new written contract if the consulting physician or designated physician has changed or if any of the information in the contract has been amended.**
13. OWNER INFORMATION – Provide a list of all the owners, officers, directors and registered agents of the facility along with their gender, date of birth, social security number, position/title, and phone number. SOCIAL SECURITY NUMBER – Social security number disclosure is required by Section 231.302(c)(1) of the Texas Family Code to obtain a license. Your social security number is subject to disclosure to an agency authorized to assist in the collection of child support payments. For more information regarding child support payments, contact the Texas Attorney General at: www.oag.state.tx.us/child/index or call (512) 460-6000 or (800) 252-8014.
14. STATEMENT OF OPERATOR AND LSO – Carefully read the statement before dating and signing your application. The LSO is also required to read the statement, sign, and date the application, if the LSO is someone other than the facility operator.

**SEND YOUR COMPLETED APPLICATION AND REQUIRED DOCUMENTS TO**:

TDLR
P.O. Box 12157
Austin, TX 78711-2157

Documents submitted with your application will not be returned. Keep a copy of your completed application, all attachments, and your check or money order. Do not send cash.

For additional information and questions, please visit the ***TDLR website***. You can request assistance or submit required attachments via ***TDLR webform*** or fax (512) 475-2871. You may contact Customer Service Representatives by calling (800) 803-9202 (in state only) or (512) 463-6599; Relay Texas -TDD (800) 735-2989. Customer Service Representatives are available Monday through Friday (excluding holidays).

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## LASER HAIR REMOVAL FACILITY CERTIFICATE OF RENEWAL APPLICATION

**RENEWAL FEE: $750.00 (FEE IS NON-REFUNDABLE)**

This completed form must be accompanied by the renewal fee.

1. Facility name:

2. DBA Name: (if applicable)

3. Certificate Number:

4. Email Address:

Ex: johndoe@aol.com See Instruction Sheet for Disclosure Information

5. Facility Phone Number:

Area Code Number

6. Facility Mailing Address:

(P.O. Box, Number, Street Name/Apartment Number, City, State, Zip Code)

7. Facility Physical Address

(Number, Street Name/Apartment Number, City, State, Zip Code)

8. Laser Hair Removal Professional:

Name: (please print)

LHR Professional Certificate Number:

9. Laser Safety Officer (LSO):

Name: (please print)

LHR Certificate or Physician License Number:(if applicable):

10. Consulting Physician Information:

Name: (please print)

Physician License Number:

Phone Number:

Area Code Number

Email Address:

Ex: johndoe@aol.com See Instruction Sheet for Disclosure Information in item 4

11. Designated Physician Information:

Name: (please print)

Physician License Number:

Phone Number:

Area Code Number

Email Address:

Ex: johndoe@aol.com See Instruction Sheet for Disclosure Information in item 4

12. **IMPORTANT: You must submit a new written contract if the consulting physician or designated physician has changed or if any of the information in the contract has been amended.**

13. Owner Information: (List all owners, officers, directors and registered agents of the facility)
(Use additional sheets, if necessary)

Name:

Last First Middle Name

Gender: ☐ Male ☐ Female

Date of Birth:

Social Security Number:

See Instruction Sheet for Disclosure Information

Position or Title:

Phone Number:

Name: _____
Last First Middle Name

Gender: ☐ Male ☐ Female Date of Birth: _____ Social Security Number: _____
See Instruction Sheet for Disclosure Information

Position or Title: _____ Phone Number: _____

Name: _____
Last First Middle Name

Gender: ☐ Male ☐ Female Date of Birth: _____ Social Security Number: _____
See Instruction Sheet for Disclosure

Position or Title: _____ Phone Number: _____

Name: _____
Last First Middle Name

Gender: ☐ Male ☐ Female Date of Birth: _____ Social Security Number: _____
See Instruction Sheet for Disclosure Information

Position or Title: _____ Phone Number: _____

Name: _____
Last First Middle Name

Gender: ☐ Male ☐ Female Date of Birth: _____ Social Security Number: _____
See Instruction Sheet for Disclosure Information

Position or Title: _____ Phone Number: _____

Name: _____
Last First Middle Name

Gender: ☐ Male ☐ Female Date of Birth: _____ Social Security Number: _____
See Instruction Sheet for Disclosure Information

Position or Title: _____ Phone Number: _____

## 14. STATEMENT OF OPERATOR AND LSO

I certify that I have read and will comply with all applicable laws and rules of the Laser Hair Removal Program including Health and Safety Code, Chapter 401, §§401.501-401.522; Occupations Code, Chapter 51; and administrative rules under 16 Texas Administrative Code, Chapters 60 and 118. I understand that providing false information on this application may result in denial of this application and/or revocation of the certification I am requesting and the possible imposition of administrative penalties.

_____
Type or Print Name of LSO

_____ _____
Signature Laser Safety Officer Date

_____
Type or Print Name of Operator

_____ _____
Signature of Operator Date