



# TEXAS DEPARTMENT OF LICENSING & REGULATION

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

[www.tdlr.texas.gov](http://www.tdlr.texas.gov)

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

The application must be completed and signed by the operator and Laser Safety Officer (LSO). An application is not considered complete and will not be processed until all required items have been submitted. All information provided must be typed or printed in **black ink**. Attachments must be submitted on separate pieces of single-sided, 8½" x 11" paper. Use a paperclip to fasten all pages together, with the check or money order on top. **Do not use staples.**

**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 facility.
2. FACILITY PHONE NUMBER – Write the telephone number, including the area code, of the facility listed.
3. FACILITY FAX NUMBER – Write the fax number, including the area code, of the facility listed.
4. EMAIL ADDRESS – By providing my email address I authorize Texas Department of Licensing and Regulation (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. 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.
6. PHYSICAL ADDRESS – Write the physical address of your facility. A post office box cannot be used for this address.
7. 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.
8. LASER SAFETY OFFICER (LSO): An LSO is an individual who has knowledge of and the authority and responsibility to apply appropriate laser radiation protection rules, standards, and practices, and who shall be specifically authorized on a certificate of LHR registration. List the name of the individual that is designated as the facility laser safety officer along with the individual's Laser Hair Removal (LHR) certificate number or Physician License number (if applicable). Give the name of the facility, the type and class of Laser/IPL equipment you have operated and the knowledge of laser radiation hazards and emergency situations.
9. CONSULTING PHYSICIAN INFORMATION – Write the consulting physician's name, license number, phone number and the email address (see item 4 for email disclosure information) in the fields provided in item 9.  
**IMPORTANT: You must submit a copy of a written contract with this consulting physician.**
10. TYPE OF OWNERSHIP – Check the box that indicates how your business is organized. You can find a description of the various types of business structures at [www.sos.state.tx.us/corp/businessstructure.shtml](http://www.sos.state.tx.us/corp/businessstructure.shtml)  
If this business is a Sole Proprietorship, Partnership, General Partnership, or Government Entity/Hospital Authority/Hospital District write your Name, Social Security Number, date of Date of Birth, mailing address, and other requested information in the provide space.  
**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](http://www.oag.state.tx.us/child/index) or call (512) 460-6000 or (800) 252-8014.  
**Email address disclosure** - 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.
11. 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.

## **DOCUMENTATION TO BE COMPLETED AND SUBMITTED WITH THE LHR FACILITY APPLICATION**

- **Submit laser experience, education and/or training for LSO.**
- **You must submit a copy of a written contract with this consulting physician**

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

Texas Department of Licensing and Regulation  
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 Texas Department of Licensing & Regulation website at [tdlr.texas.gov](https://tdlr.texas.gov) or reach Customer Service via web form. The web form will allow you to submit your request for assistance and include attachments needed at <https://tdlr.texas.gov/help>. You may also reach us at (800) 803-9202 [in state only], (512) 463-6599, Relay Texas-TDD: (800) 735-2989 or Fax: (512) 463-9468. Customer Service Representatives are available Monday through Friday 7:00 a.m. until 6:00 p.m. Central Time (excluding holidays).



9. Consulting Physician:

Name: \_\_\_\_\_ Physician License Number: \_\_\_\_\_  
(please print)

Phone Number: \_\_\_\_\_ Area Code \_\_\_\_\_ Number \_\_\_\_\_ Email Address: \_\_\_\_\_  
(Ex: johndoe@aol.com) See instruction sheet for disclosure information

10. Type of Ownership: (check only one box for the type of ownership)

**COMPLETE THE APPROPRIATE SECTION FOR THE APPLICABLE FACILITY. INCOMPLETE FORMS WILL DELAY THE APPLICATION PROCESS.**

For information concerning the Texas Secretary of State (SOS) file number call 512-463-5555 or 800-252-1381, or 800-252-1381, or visit: [www.sos.state.tx.us](http://www.sos.state.tx.us). The Federal Employer Identification Number (FEIN) also known as "Federal Tax ID Number" is a 9-digit number assigned by the Internal Revenue Service (IRS).

**Sole Proprietor:** (One individual)

Name: \_\_\_\_\_

Social Security Number or Federal Tax Identification Number: \_\_\_\_\_ Owner Date of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_  
(Ex: johndoe@aol.com) See instruction sheet for disclosure information

Mailing Address: \_\_\_\_\_  
(P.O. Box, Number, Street Name, City, State, and Zip Code)

**Partnership:** (Two or more individuals) (For Additional Partners Complete Another Sheet)

Name of Partner # 1: \_\_\_\_\_

Social Security Number or Federal Tax ID #: \_\_\_\_\_ Owner Date of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_  
(Ex: johndoe@aol.com) See instruction sheet for disclosure information

Mailing Address: \_\_\_\_\_  
(P.O. Box, Number, Street Name, City, State, and Zip Code)

Name of Partner # 2: \_\_\_\_\_

Social Security Number or Federal Tax ID #: \_\_\_\_\_ Owner Date of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_  
(Ex: johndoe@aol.com) See instruction sheet for disclosure information

Mailing Address: \_\_\_\_\_  
(P.O. Box, Number, Street Name, City, State, and Zip Code)

**FOR ADDITIONAL PARTNERS COMPLETE ANOTHER SHEET**

**Corporation, Limited Company, or General Partnership:** (example Corporation, LLC, LP, LLP)

Name of  
Business Entity: \_\_\_\_\_

Federal Tax ID  
(FEIN): \_\_\_\_\_

Texas SOS File #: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email  
Address: \_\_\_\_\_  
(Ex: johndoe@aol.com) See instruction sheet for disclosure information

Mailing Address: \_\_\_\_\_  
(P.O. Box, Number, Street Name, City, State, and Zip Code)

**List all officers, directors and registered agents of the corporation. (Use additional sheets, if necessary.)**

Name: \_\_\_\_\_  
Last First Middle Name

Gender:  Male  Female Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Position or Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle Name

Gender  Male  Female Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Position or Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Government Entity/Hospital Authority/Hospital District**

Entity Name: \_\_\_\_\_ Federal Tax ID  
(FEIN): \_\_\_\_\_

Phone #: \_\_\_\_\_ Email  
Address: \_\_\_\_\_  
(Ex: johndoe@aol.com) See instruction sheet for disclosure information

Mailing Address: \_\_\_\_\_  
(P.O. Box, Number, Street Name, City, State, and Zip Code)

11.

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 of Designated Laser Safety Officer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type or Print Name of Operator

\_\_\_\_\_  
Signature of Operator

\_\_\_\_\_  
Date