**LASER HAIR REMOVAL FACILITY NOTICE OF CHANGE AND DUPLICATE REQUEST INSTRUCTIONS**

You must apply for a new LHR Facility Certificate of Registration if there is a change in ownership.

All information provided must be typed or printed in black ink.

1. **CURRENT NAME OF THE LHR FACILITY** – Write the facility name as it currently appears on the Laser Hair Removal (LHR) facility certificate.
2. **LHR FACILITY CERTIFICATE NUMBER** – Write the LHR facility certificate number.
3. **DUPLICATE CERTIFICATE REQUEST** – Check the appropriate box. Non-refundable fee of $25 required for a duplicate certificate.
4. **NOTIFICATION OF CHANGE** – Check the appropriate box(es).
5. **NEW FACILITY’S NAME** – Write the new LHR facility name as reflected on the ASSUMED NAME filing with the County Clerk or Secretary of State (SOS). You must provide a copy of the Assumed Name Filing with the County Clerk or Secretary of State with this form.
6. **NEW CERTIFIED LHR PROFESSIONAL’S NAME** – Write the new Certified LHR Professional’s name.
7. **CERTIFIED LHR PROFESSIONAL CERTIFICATE NUMBER** – Write the new Certified LHR Professional’s Certificate Number.
8. **NEW CONSULTING PHYSICIAN’S NAME** – Write the new Consulting Physician’s Name. You must submit a copy of the written contract for this LHR Facility
9. **NEW FACILITY’S MAILING ADDRESS** – Write your new mailing address in the spaces provided. This is the address where we will send you mail. This address can be a post office box.
10. **NEW FACILITY’S PHYSICAL ADDRESS** – Write your new physical address in the spaces provided.
11. **NEW FACILITY’S PHONE NUMBER** – Write your new phone number, including the area code.
12. **NEW FACILITY’S EMAIL ADDRESS** – Write your new 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.
13. **STATEMENT OF APPLICANT** – Carefully read, print the name, and title of the person requesting the change(s), and must be signed and dated.

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 https://www.tdlr.texas.gov or reach Customer Service via webform where you can submit your request for assistance and include attachments needed at https://www.tdlr.texas.gov/help or (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).

TDLR Form LAS014 rev November 2016
**DUPLICATE LICENSE FEE: $25 (FEE IS NON-REFUNDABLE)**

All information provided must be typed or printed in black ink.

<table>
<thead>
<tr>
<th>序号</th>
<th>内容</th>
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<tbody>
<tr>
<td>1</td>
<td>Name of the LHR facility:</td>
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<tr>
<td>2</td>
<td>LHR Facility Certificate Number:</td>
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</tbody>
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**DUPLICATE CERTIFICATE REQUEST**

3. **Duplicate Certificate Request** (check the box that applies)
   - [ ] Yes ($25 fee required)
   - [ ] No

**NOTIFICATION OF CHANGE**

4. **Notification of change:** (check the box that applies)
   - [ ] Facility’s Name (supporting documents required, see instructions in item 5)
   - [ ] Consulting Physician (Submit a copy of a written contract with the LHR Facility)
   - [ ] Certified LHR Professional
   - [ ] Facility’s Contact information

5. New Facility’s name: |

6. New Certified LHR Professional’s name: |

7. Certified LHR Professional Certificate Number: |

8. New Consulting Physician Name: |

9. New Facility’s Mailing Address: (P.O. Box, Number, Street Name, Suite Number)

10. New Facility’s Physical Address: (P.O. Box, Number, Street Name, Suite Number)

11. New Facility’s Phone Number: |

12. New Facility’s Email Address: (Ex: johndoe@gmail.com) See Instructions sheet for Disclosure)

13. **STATEMENT OF OPERATOR**

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.

Signature of Operator  Date