TEXAS DEPARTMENT OF LICENSING & REGULATION
P.O. Box 12157 • Austin, Texas 78711-2157
www.tdlr.texas.gov

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:

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).

TDLR Public Information Act Policy:
This document is subject to the Texas Public Information Act. With certain exceptions, information in this document may be made available to the public. For more information, view the ***TDLR Public Information Act Policy***.

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DUPLICATE LICENSE FEE: $25.00 (FEE IS NON-REFUNDABLE)

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

1. Name of the LHR facility: Please Print

2. LHR Facility Certificate Number:

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) City State Zip Code

10. New Facility's Physical Address:

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

11. New Facility's Phone Number:

(Area Code) 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