



# 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 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).



# 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

DO NOT WRITE ABOVE THIS LINE

**DUPLICATE LICENSE FEE: \$25 (FEE IS NON-REFUNDABLE)**

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

1. Name of the LHR facility:	2. LHR Facility Certificate Number:
------------------------------	-------------------------------------

Please Print

### 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:

12. New Facility's Email Address:

Area Code Ph. Number (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