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

LASER HAIR REMOVAL FACILITY LICENSE APPLICATION INSTRUCTIONS

The application must be completed and signed by the owner and/or operator and Laser Safety Officer (LSO). An application is not considered complete and will not be processed until all required items have been submitted.

An application is not complete until all required documentation / information and fees are received. Fees may be paid by personal check, business check, money order, or cashier's check made payable to the Texas Department of Licensing and Regulation. Do not send cash. Credit card payments may be made through the online licensing system.

1. FACILITY NAME: Full legal name of facility.
2. FACILITY PHONE NUMBER: Provide the telephone number, including the area code, of the facility listed.
3. 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.
4. MAILING ADDRESS: Provide your current mailing address. This is the address where we will send you mail. This address can be a post office box. Add the zip plus-4 to help the postal service deliver mail more efficiently and accurately.
5. PHYSICAL ADDRESS: Indicate the physical address of the facility. A post office box cannot be used for this address.
6. LASER HAIR REMOVAL (LHR) PROFESSIONAL: List the name of the individual that is designated as the facility Laser Hair Removal (LHR) Professional along with their LHR license number.
7. LASER SAFETY OFFICER (LSO): A Laser Safety Officer (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 designated on a LHR facility license. List the name of the individual that is designated as the facility LSO along with the individual's LHR license number or physician's 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.
8. CONSULTING PHYSICAN INFORMATION: Indicate the consulting physician's name, license number, phone number, and email address (see item #11 for email disclosure information).
9. DESIGNATED PHYSICAN INFORMATION: Indicate the designated physician's name, license number, phone number, and email address (see item #11 for email disclosure information).
10. TYPE OF OWNERSHIP: Check the box that indicates how your business is organized. For a description of various types of businesses visit the ***Texas Secretary of State***.
    If this business is a sole proprietorship, partnership, general partnership, or government entity/hospital authority/hospital district provide your name, Social Security number, date of birth, mailing address, and other requested information in the provided space.
    Social Security Number Disclosure: Your Social Security number is required by Section 231.302(c)(1) of the Texas Family Code to obtain a license and 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***.
    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. FACILITY OWNER ATTESTATION: The LHR facility owner or operator must initial all items listed on the attestation to confirm that they have complied with the requirements of the written contract with the consulting physician in accordance with the LHR law and rules.
12. STATEMENT AND SIGNATURES OF LHR FACILITY OPERATOR AND PHYSICIANS: Signatures are required of the LHR facility owner or operator, consulting physician, and designated physician. Please read the statement carefully before signing and dating your application.

SEND YOUR COMPLETED APPLICATION AND FEE 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, documents, and your check or money order. Do not send cash.

Notify TDLR of any changes to a response provided on the application within 30 days. Failure to do so could result in the denial or revocation of license. Examples: change of address, business type, type of facility, or an incorrect answer to a question.

For additional information and questions, visit the ***TDLR website*** or reach Customer Service via ***webform***. The ***webform*** will allow you to submit your request for assistance and include attachments needed. Customer Service Representatives are available Monday through Friday (excluding holidays) at (800) 803-9202 (in state only), (512) 463-6599, or Relay Texas-TDD: (800) 735-2989.

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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LASER HAIR REMOVAL FACILITY LICENSE APPLICATION

APPLICATION FEE $900.00 (APPLICATION FEE IS NON-REFUNDABLE)

This application must be completed and submitted with required documents and fee.

1. Facility Name: _____

2. Facility Phone Number: _____ (Area Code) Phone Number

3. Email Address: _____ (Ex: johndoe@aol.com) See instructions for disclosure statement.

4. Mailing Address:

_____ Street Number & Name Apt/Bldg/Ste # _____ City _____ State _____ Zip Code + 4

5. Physical Address (PO Box cannot be used for this address):

_____ Street Number & Name Apt/Bldg/Ste # _____ City _____ State _____ Zip Code +4

6. Laser Hair Removal Professional Name: _____

LHR Professional License Number: _____

7. Laser Safety Officer (LSO)

LSO Name: _____

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

Phone Number: _____ (Area Code) Phone Number

Email Adress: _____ (Ex: johndoe@aol.com) See instructions for disclosure statement.

Mailing address:

_____ Street Number & Name Apt/Bldg/Ste # _____ City _____ State _____ Zip Code + 4

Documentation of Device Experience

Name of Facility	Type and Class of Laser/IPL Equipment Operated	Knowledge of Laser Radiation Hazards and Emergency Situations

Submit documentation of laser experience, education and/or training. The following are examples of what will qualify an individual as an LSO.

- Educational courses related to laser radiation safety or a laser safety officer course (e.g. training certificates, etc.); or
- Experience using or familiarity with the type of equipment used (e.g. training obtained from manufacture/in-house training, etc.); and
- Knowledge of potential laser radiation hazards and laser emergency.

If the LSO holds a LHR license or is a licensed physician, no additional documentation is required.

8. Consulting Physician:

Name: (please print) _____ Physician License Number: _____

Phone Number: _____ (Area Code) Phone Number

Email Address: _____ (Ex: johndoe@aol.com) See instructions for disclosure statement.

9. Designated Physician:

Name: (please print) _____ Physician License Number: _____

Phone Number: _____ (Area Code) Phone Number

Email Address: _____ (Ex: johndoe@aol.com) See instructions for disclosure statement.

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 more file number information visit the ***Texas Secretary of State (SOS)***. 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)

Last _____ First _____ Middle _____ Suffix (Jr., Sr., III) _____

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

Phone Number: _____ (Area Code) Phone Number

Email Address: _____ (Ex: johndoe@aol.com) See instructions for disclosure statement.

Mailing Address:

_____ Street Number & Name Apt/Bldg/Ste # _____ City _____ State _____ Zip Code + 4

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

Name of Partner #1: _____

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

Phone Number: _____ (Area Code) Phone Number

Email Address: _____ (Ex: johndoe@aol.com) See instructions for disclosure statement.

Mailing Address:

_____ Street Number & Name Apt/Bldg/Ste # _____ City _____ State _____ Zip Code + 4

Name of Partner #2: _____

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

Phone Number: _____ (Area Code) Phone Number

Email Address: _____ (Ex: johndoe@aol.com) See instructions for disclosure statement.

Mailing Address:

_____ Street Number & Name Apt/Bldg/Ste # _____ City _____ State _____ Zip Code + 4

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 Number: _____ (Area Code) Phone Number

Email Address: _____ (Ex: johndoe@aol.com) See instructions for disclosure statement.

Mailing Address:

_____ Street Number & Name Apt/Bldg/Ste # _____ City _____ State _____ Zip Code + 4

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

Name:

_____ Last _____ First _____ Middle _____ Suffix (Jr., Sr., III)

Gender: ☐ Male ☐ Female

Date of Birth: _____

Social Security Number: _____

Position or Title: _____

Phone Number: _____ (Area Code) Phone Number

Name:

_____ Last _____ First _____ Middle _____ Suffix (Jr., Sr., III)

Gender: ☐ Male ☐ Female

Date of Birth: _____

Social Security Number: _____

Position or Title: _____

Phone Number: _____ (Area Code) Phone Number

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

Entity Name: _____

Federal Tax ID (FEIN): _____

Phone Number: _____ (Area Code) Phone Number

Email Address: _____ (Ex: johndoe@aol.com) See instruction sheet for disclosure information

Mailing Address:

_____ Street Number & Name Apt/Bldg/Ste # _____ City _____ State _____ Zip Code + 4

12. FACILITY OWNER ATTESTATION

In accordance with Health and Safety Code, Chapter 401, Sections 501-522 (law) and 16 Texas Administrative Code, Chapter 118 (rules), the Laser Hair Removal Facility owner, or operator must have a written contract with the consulting physician listed on this application. The consulting physician and designated physician must hold a current license in Texas as a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.).

The written contract between the LHR facility owner/operator and the consulting physician must be on-site and available to the department upon request.

The LHR facility owner/operator must initial each space provided below to signify compliance with each item. **Do not leave any items blank.**

_____ 1. I have a written contract with the consulting physician in accordance with Laser Hair Removal law and rules. The contract is specific to laser hair removal and does not contain references to any other services such as photo facials, skin rejuvenation, Botox, fillers, etc.

_____ 2. The consulting physician and designated physician both have a primary practice site located within 75 miles of the LHR facility. Physician's license and primary practice site is verified through the Texas Medical Board website.

_____ 3. The contract includes proper protocols for the services provided by the consulting physician at the facility as specified in §118.60. The contract includes a statement addressing each of the following protocols:

- The levels of LHR licensure that will be employed and/or directly supervised,
- Circumstances or conditions under which each procedure is to be performed,
- Must have a signed consent form prior to LHR procedures,
- Client history including medications currently being taken,
- List of medications that if taken by the client must be reported to the consulting physician before LHR services can be performed or which preclude a LHR service from being provided,
- Contraindications that prevent a procedure from being performed,
- LHR procedures must be performed in a clean environment, and
- Conditions under which emergency consultation is required.

_____ 4. The contract includes a provision for the consulting physician to audit the LHR facility's protocols and operations in accordance with §118.61.

_____ 5. The consulting physician shall be available for emergency consultation with the LHR facility as appropriate to the circumstances, including, if the physician considers it necessary, an emergency appointment with the client.

_____ 6. The designated physician shall be available for consultation with the LHR facility relating to care for the client if the consulting physician is unavailable.

_____ 7. LHR devices must be used in accordance with the manufacturer's instructions at which the LHR device can expected to safely remove hair.

13. STATEMENT AND SIGNATURES OF LHR FACILITY OPERATOR AND PHYSICIANS

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.

Print Name of LHR Facility Owner or Operator	Signature of LHR Facility Owner or Operator	Date
Print Name of Consulting Physician	Signature of Consulting Physician	Date
Print Name of Designated Physician	Signature of Designated Physician	Date