



TEXAS DEPARTMENT OF STATE HEALTH SERVICES (DSHS)
 RADIATION SAFETY LICENSING BRANCH (RSLB)
 Mail Code 2835
 P.O. Box 149347
 Austin, Texas 78714-9347

FOR AGENCY USE ONLY	
FILE NO.	_____
APP. NO.	_____

REGISTRATION APPLICATION FOR LASER HAIR REMOVAL SENIOR TECHNICIAN

Complete ALL ITEMS on the application including required signatures and sample formats on page 2. For further questions, contact the RSLB at (512)834-6688, ext. 2225. Upon approval of the application, the applicant will receive a Certificate of Registration.

For new, renewal, and upgrade registrations, mail application and fees to DSHS, RSLB, Mail Code 2003, P. O. Box 149347, Austin Texas, 78714-9347. All other actions should use the address at the top of the application.

1. Legal Name of Individual: _____	
2. Mailing Address: (Street Address/City/State/Zip/County) _____ _____	
3. Phone Number: _____	4. Fax No.: _____
5. E-mail address: _____	6. Date of Birth: _____

7. Type of action: (Check all that apply)

New Registration (for Medical Doctor and Doctor of Osteopathy use only)

Amendment to Registration No. **ZP** _____

Name Change

Address Change

Upgrade Individual Certification Current Registration No. **ZP** _____

Renewal of Registration No. **ZP** _____

I certify that continuing education (CE) requirements have been met. DO NOT send CE documentation at this time. If you are selected for CE audit, documentation will be requested at that time.

You must have a technician certificate issued by this agency before submitting this form.

8. I certify that I have read and understand the applicable rules and agree to comply with them. I understand that it is a violation of DSHS rules and the Texas Penal Code 37.10 to submit any false or fraudulent information or documents in order to obtain a certificate of registration. All information I have provided on this application is true, correct, and complete to the best of my knowledge.

_____	_____	_____
Typed or printed name of applicant	Date	Signature

PRIVACY NOTIFICATION: If you are applying as an individual, with few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Format for Documentation of Having Directly Supervised 100 Laser Hair Procedures
Every space must be completed. Do not leave blank spaces.
Please make copies.

<u>Date of Procedure</u>	<u>Client ID # or Initials*</u>	<u>Type of Procedure**</u>	<u>Name of Supervised Individual</u>	<u>Name of LHR Professional Performing Audit***</u>	<u>Professional's Registration Number</u>
1.					
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*Please do not submit patient's name per Health Insurance Portability and Accountability Act (HIPAA).

**In accordance with Texas Administrative Code §289.302(d)(20).

***I attest that as a LHR Professional I have audited this individual's supervision.

LHR Professional Signature _____

Printed Name _____

Date _____

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