STATE OF TENNESSEE
DEPARTMENT OF HEALTH
Bureau of Health Licensure and Regulation
Division of Health Related Boards
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243
www.tennessee.gov

(800) 778-4123 or (615) 532-3202

APPLICATION INSTRUCTIONS AND REQUIREMENTS FOR REGISTRATION OF A MEDICAL SPA

NOTE: AN APPLICANT SHALL SUBMIT A SEPARATE APPLICATION FOR REGISTRATION FOR EACH SPA REGARDLESS OF WHETHER THE SPA IS OPERATED UNDER THE SAME BUSINESS NAME, OWNERSHIP, OR MANAGEMENT AS ANOTHER SPA.

1. Any medical director or supervising physician who is responsible for or supervises a medical spa must register the medical spa with the Board of Medical Examiners. A "medical spa" is any entity, however named or organized, which offers or performs cosmetic medical services.

2. "Cosmetic medical service" means any service that uses biologic or synthetic material, a chemical application, a mechanical device, or a displaced energy form of any kind that alters or damages, or is capable of altering or damaging, living tissue to improve the patient's appearance or achieve an enhanced aesthetic result.

3. To register a medical spa, the medical director must submit this application and all required fees directly to:

Board of Medical Examiners
ATTN: Medical Spa Registration
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243 (37228 for courier service only)
FAXED OR EMAILED APPLICATIONS WILL NOT BE ACCEPTED

4. The medical director and supervising physician(s) must have an active medical practice in Tennessee. Accordingly, please provide the name and address of the medical director and all supervising physicians' primary practice on the application.

5. All application fees are non-refundable.

6. **Please allow fourteen (14) working days** for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred. We ask that you please give the office every consideration in this matter.

7. If necessary documentation has not been received when your application has been received by the office, an initial deficiency letter will be sent to you. **If an applicant does not complete the application process within sixty (60) days after the Department receives the application because the application lacks the required information or fails to meet the prerequisites for registration, then the application will be closed, the application fee will not be refunded, and the applicant shall reapply for registration.**

8. Any application that is submitted to the Department may be withdrawn at any time prior to the grant or denial of registration; provided, however, that the application fee will **not** be refunded.

9. Once the application is completed, the file will be reviewed, a registration determination made, and you will be promptly notified.

10. If an address change occurs at any time during the application process, you must notify the office, in writing, immediately**.**

11. If any information required by the application for registration changes at any time, written notification must be provided to the Board of Medical Examiners within thirty (30) days of any such change. Written notification may be submitted by US mail to the address above or by facsimile to (615) 253-4484, attention: Medical Spa Registration.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 Mainstream Drive, 2nd Floor
NASHVILLE, TN 37243

www.tennessee.gov

APPLICATION FOR REGISTRATION OF MEDICAL SPA

Please Print In Ink

Please Check One:

☐ I am a Medical Doctor ☐ I am an Osteopathic Physician

Please Check One:

☐ I am applying for initial registration ☐ I am renewing an existing registration

Name of Medical Spa: _____

FEIN: _____

Address of Medical Spa: _____

_____

Phone Number: (_____) _____ Fax Number: (_____) _____

The **Medical Director** named below holds an **active** Tennessee medical license and shall personally provide, or supervise the provision of, all cosmetic medical services occurring in this medical spa. Any **Medical Director** supervising the provision of cosmetic medical services must have an **unencumbered** license:

MEDICAL DIRECTOR **Would you like our records updated with the information provided below? Y ☐ N ☐**

Name: _____
Last First Middle Maiden

Primary Practice Name and Address: _____

Phone Number(s) Home: (___) _____ Office: (___) _____

Tennessee License Number: _____ Date Issued: _____

Board certification of Medical Director: ☐ Board certified ☐ Board eligible ☐ Neither

If medical director is board certified or board eligible, please specify specialty or subspecialty (e.g., neurology, internal medicine) and certifying body (i.e., ABMS, AOA): _____

_____

If certification is by board or association other than the ABMS or AOA, please specify board/association and whether requirements are ABMS or AOA equivalent: _____

_____

If certification is by board or association other than the ABMS or AOA, please specify board/association and whether certification requires completion of an ACGME or AOA approved training program that provides complete training in the specialty or subspecialty certified, followed by certification by a certifying board of the ABMS or AOA in that training field and successful completion of an additional examination in the specialty or subspecialty certified: _____

_____

Please identify any physician, other than the Medical Director, who may personally provide or supervise the provision of cosmetic medical services occurring in this medical spa.

Supervising Physician 1 (supervising physician must have an active and unencumbered license in order to supervise any other provider) **Would you like our records updated with the information provided below? Y ☐ N ☐**

Name: _____
Last First Middle Maiden

Primary Practice Address: _____

Phone Number(s) Home: (___) _____ Office: (___) _____

Tennessee License Number: _____ Date Issued: _____

If supervising physician is board certified or board eligible, please specify specialty or subspecialty (e.g., neurology, internal medicine) and certifying body (i.e., ABMS, AOA): _____

_____

If certification is by board or association other than the ABMS or AOA, please specify board/association and whether requirements are ABMS or AOA equivalent: _____

_____

If certification is by board or association other than the ABMS or AOA, please specify board/association and whether certification requires completion of an ACGME or AOA approved training program that provides complete training in the specialty or subspecialty certified, followed by certification by a certifying board of the ABMS or AOA in that training field and successful completion of an additional examination in the specialty or subspecialty certified: _____

_____

Supervising Physician 2 (supervising physician must have an active and unencumbered license in order to supervise any other provider) **Would you like our records updated with the information provided below? Y ☐ N ☐**

Name: _____
Last First Middle Maiden

Primary Practice Address: _____

Phone Number(s) Home: (___) _____ Office: (___) _____

Tennessee License Number: _____ Date Issued: _____

If supervising physician is board certified or board eligible, please specify specialty or subspecialty (e.g., neurology, internal medicine) and certifying body (i.e., ABMS, AOA): _____

_____

If certification is by board or association other than the ABMS or AOA, please specify board/association and whether requirements are ABMS or AOA equivalent: _____

_____

If certification is by board or association other than the ABMS or AOA, please specify board/association and whether certification requires completion of an ACGME or AOA approved training program that provides complete training in the specialty or subspecialty certified, followed by certification by a certifying board of the ABMS or AOA in that training field and successful completion of an additional examination in the specialty or subspecialty certified: _____

_____

If more than two physicians will supervise services provided in the spa, please identify those physicians, including the information specified above, on a separate sheet of paper.

I affirm that the statements given in this attachment are true and correct.

_____	_____	_____
(Medical Director's Signature)	(License No.)	(Date)

I affirm that I have read **TENN. CODE ANN. § 63-1-153.**

_____	_____	_____
(Medical Director's Signature)	(License No.)	(Date)