

Dear Applicant:

RE: Cosmetic Therapy Examination

Attached is an application and instructions for the Cosmetic Therapy Examination. **PLEASE READ THE INSTRUCTIONS THOROUGHLY BEFORE COMPLETING THE APPLICATION.** You must complete the entire application and submit all required documentation.

Please note that once submitted an application cannot be withdrawn without the approval of the Board. Fees submitted are neither refundable nor transferable, even if a withdrawal is permitted.

It is important you understand that **under Ohio law no provisions exist for temporary or provisional licensure while your request for licensure is being processed.** **The practice of Cosmetic Therapy prior to licensure constitutes a criminal offense.**

All applicants applying to sit for the Cosmetic Therapy examination in Ohio must submit the completed application and application fee no later than the posted deadline date. **APPLICATIONS RECEIVED WITHOUT THE FEE WILL NOT BE ACCEPTED FOR THE EXAM AND WILL BE RETURNED.**

Exam dates and deadlines are as follows:

Exam Date

September 25, 2015

October 2, 2015

Application Deadline

August 21, 2015

August 21, 2015

PLEASE NOTE: Any applicant graduating prior to September 1, 2015, will sit for the September 25, 2015 exam date. Any applicant graduating on September 1, 2015 will sit for the October 25, 2015 exam date. Any applicant failing to comply with the above-mentioned instructions will not be allowed to sit for either Cosmetic Therapy examination in Ohio under any circumstances.

Attachments:

COSMETIC THERAPY APPLICATION CHECKLIST

This checklist is for your use and to help you determine the items you will be required to submit with your application for the cosmetic therapy examination. Once your application is received an "Online Application Status" letter will be mailed to you. This letter will allow you to check the status of your application online.

ALL APPLICANTS MUST:

- Complete the **APPLICATION FOR CERTIFICATE – COSMETIC THERAPY** in its entirety including:
 - RESUME OF ACTIVITIES** - You must list ALL activities for the last five years to the present time. Even if not working, indicate your activities and home address for that time. If you have been out of high school for less than five years, only list activities starting with high school graduation to the present time. Be sure to use business addresses for all working time.
 - ADDITIONAL INFORMATION QUESTIONS (1 through 21)** - Please be advised that you must thoroughly explain any affirmative answers. You must give your account of the event(s). If you answer yes to Question 14, you must complete and submit the Criminal Offense Information form in its entirety. You must also submit copies of all relevant documentation, such as a copy of the police report/arrest record, a copy of the charge/ticket and a copy of the final court disposition. Please note that some questions specifically ask for **certified** documents.
 - AFFIDAVIT AND RELEASE OF APPLICANT** - This form must be notarized.
- Enclose the application fee of **\$250.00**. Make check or money order payable to **Ohio Treasurer**. *Fees are neither refundable nor transferable. DO NOT SEND CASH!*
- BCI&I AND FBI BACKGROUND CHECKS** - Request a criminal records check from the Ohio BCI&I and FBI (refer to the Criminal Records Check instruction sheet for additional information).
- FORM 1 – CERTIFICATE OF RECOMMENDATION** - Attach a recent (taken within the last six months) passport-type **COLOR** photo to each of the two Certificates of Recommendation, sign your name and indicate the date your photo was taken beneath your photograph, and forward to two residents of the state in which you are residing who will complete, including obtaining notarization, these recommendations. The residents you choose to complete each form must have known you at least six months. Relatives may not serve as recommenders. Black and white photos will not be accepted.
- FORM 2 - CERTIFICATE OF EDUCATION** - This form must be completed by the President, Dean or Secretary of the school of graduation or their designee. This form is not to be completed **prior** to graduation. *(Please note that if you have not yet graduated your school will forward the Form 2 to the Board)*
- Enclose a photocopy of your cosmetic therapy diploma. *(Please note that if you have not yet graduated your school will forward a copy of your diploma to the Board)*

APPLICATION INSTRUCTIONS

Review the following instructions and the entire application packet carefully before completing the application. Processing will not begin until the appropriate fee is received. Failure to submit all required information and documentation will result in processing delays.

1. Fill out the enclosed **APPLICATION FOR CERTIFICATE – COSMETIC THERAPY** in its entirety. You must provide a response to each section or question of the application as instructed. Mark “N/A” if Not Applicable.
2. Submit a check or money order in the amount of **\$250.00** made payable to **Ohio Treasurer**, with your completed application. **FEES SUBMITTED ARE NEITHER REFUNDABLE NOR TRANSFERABLE. DO NOT SEND CASH.**
3. Request a criminal records check from the Ohio BCI&I and FBI (refer to the Criminal Records Check instruction sheet for additional information).
4. Attach a recent (taken within the last six months) passport-type **COLOR** photo to each of the two Certificates of Recommendation (Form 1), sign your name and indicate the date your photo was taken beneath your photographs, and forward to two residents of the state in which you are residing who will complete these recommendations. The residents you choose to complete each form must have known you at least six months. Relatives may not serve as recommenders. Black and white photos will not be accepted.
5. Enclose a photocopy of your cosmetic therapy diploma. ***(Please note that if you have not yet graduated your school will forward a copy of your diploma to the Board)***
6. Forward the enclosed Certificate of Education (Form 2) to the school where you completed your cosmetic therapy training. This form must be completed by the President, Dean or Secretary of the school of graduation or their designee. This form is not to be completed **prior** to graduation. ***(Please note that if you have not yet graduated your school will forward the Form 2 to the Board)***
7. If you have changed your name, you must submit a photocopy of the appropriate legal document which authorizes each name change. This may be a court decree and/or a marriage certificate. Any document in a foreign language must be accompanied by an official, certified translation.
8. **Definitions:** The following phrases or words in the Additional Information Questions have the following meaning:
 - a. “Ability to practice cosmetic therapy” includes the following:
 - i. The cognitive capacity to make appropriate clinical assessments and exercise reasoned judgments and to learn and keep abreast of developments in the field of cosmetic therapy; and

- ii. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
 - iii. The physical capability to perform cosmetic therapy with or without the use of aids or devices, such as corrective lenses or hearing aids.
- b. "Medical condition" includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.
 - c. "Chemical substances" includes alcohol, drugs or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.
 - d. "Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.
 - e. "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.
9. Mail your completed application and fee directly to the Ohio Board at the following address:

State Medical Board of Ohio
30 E. Broad Street, 3rd Floor
Columbus, OH 43215-6127

THE COMPLETED APPLICATION **AND** FEE MUST BE RECEIVED IN THE BOARD OFFICES **NO LATER THAN AUGUST 21, 2015.**

ADDITIONAL INFORMATION

American's with Disabilities Act of 1990 (ADA)

Under the ADA the Board will provide accommodations to exam applicants diagnosed with a disability. Applicants will be required to submit documentation of their disability, including medical documentation and if any accommodations were granted in the past. An applicant must notify the Board no later than the final application deadline that he/she has a disabling condition and is requesting special testing accommodations. To accelerate the review process, applicants are urged to submit their request and supporting documentation as early in the application process as possible.

Application Process

The State Medical Board processes hundreds of applications for each examination. Applications are processed in the order in which they are received. An incomplete application or any unusual circumstances discovered during processing will result in a delay. You will be notified if the application is incomplete or contains errors.

Additional Information Section

Please keep a copy of the Additional Information Questions for your own reference. If any answers to these questions change while your application is pending, you must notify the State Medical Board in writing.

Admission to the Examination

Notification of specific dates, times and places will be furnished not less than thirty days in advance. An incomplete application or any unusual circumstances discovered during processing will result in deviation from this schedule. If you are unable to sit for the examination you must notify the Board in writing, including the reason why you are unable to take the examination, as soon as possible.

Examination Results

Results of the examination are tentatively scheduled for release approximately 2 months after the administration of the examination. Applicants will be notified by mail of the examination results. Applicants who do not pass the examination will be mailed an application to reapply for the next examination.

Licensure Letter, Wallet Card and Wall Certificate

Upon issuance of an Ohio license number, a letter of notification will be sent to you. That letter will serve as legal authorization to practice in Ohio. A wallet card and wall certificate will be mailed approximately one month after licensure. Hospitals, insurance companies, etc., must obtain verification of your Ohio license directly from the Board's website. The Ohio Medical Board website address is <http://med.ohio.gov> in the "Licensee Profile and Status section. The website is updated immediately to reflect newly issued licenses.

Display of Wall Certificate

The wall certificate, by law, must be displayed in your office or the place where a major portion of your practice is conducted.

Renewal

The Ohio Medical Board operates a "staggered renewal" system based upon the first letter of your last name at the time of licensure. Each licensee will remain in their originally assigned group for all subsequent renewals. There are eight renewal groups; each group has its own renewal and expiration dates. Each renewal period after the initial renewal period is two years long.

CRIMINAL RECORDS CHECK REQUIRED FOR INITIAL LICENSURE
MESSAGE THERAPIST (LMT)
COSMETIC THERAPIST(CT)

Chapter 4731 of the Ohio Revised Code requires all individuals applying for an initial license with the State Medical Board of Ohio to submit fingerprints for a criminal records check completed by the Ohio Bureau of Criminal Identification and Investigation (BCII) and the Federal Bureau of Investigation (FBI).

Instructions for Individuals Residing in Ohio

Applicants residing in Ohio are required to utilize "WebCheck," Ohio's electronic fingerprint system, to electronically submit their fingerprints to BCII. The Board will typically receive the results of criminal records check submitted via "WebCheck" within 7 to 10 business days. In addition to the BCII fee and FBI fee, the electronic fingerprinting company/agency may charge a handling fee to process the fingerprints.

Since the law requires applicants for licensure to submit a criminal records check completed by both BCII and the FBI, applicants **MUST** use the services of a vendor that participates in the "WebCheck." The Sheriff's offices in all 88 Ohio counties participate in the "National WebCheck." A list of all vendors, searchable by county, is available online at:

<http://www.ag.state.oh.us/business/fingerprint/data/index.asp>

When locating an electronic fingerprinting site on this web page, please note that you **MUST use the services of a vendor that has (BCI and FBI) listed after the vendor's name.** Only these entities participate in "National WebCheck". The Board does not endorse or recommend any specific electronic fingerprinting company/agency.

You need both the BCII and FBI criminal records check for initial licensure. By law, the Board cannot complete the processing of your application until it receives the background check reports from both BCII and FBI.

Steps for "National WebCheck"

- Identify a "**BCI and FBI**" vendor that participates in the "National WebCheck".
- Submit your fee directly to the vendor. **DO NOT SEND YOUR FINGERPRINTS OR FEE TO THE BOARD.**
- Request that the criminal records check results from both BCII and FBI be sent directly to:

**State Medical Board of Ohio
30 E. Broad St., 3rd Floor
Columbus, Ohio 43215-6127**

- Indicate the reason for fingerprinting as "Required for licensure per ORC 4731.171".
- List the agency code as **1AB002**.

Instructions for Individuals Residing Outside Ohio

Individuals residing outside Ohio must contact the Board by email at med.license@med.ohio.gov to request the appropriate forms. The Board will mail the forms needed for your fingerprints to be processed at your local law enforcement agency.

APPLICATION FOR CERTIFICATE TO PRACTICE A LIMITED BRANCH

COSMETIC THERAPY

PLEASE TYPE OR PRINT CLEARLY

NOTE: Application fee is \$250.00. Fees submitted are neither refundable nor transferable.

IDENTIFICATION

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. §1320a-7e(b), 5 U.S.C. §552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. §666 and §3123.50, O.R.C.). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. §11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with Chapters 4730., 4731., 4760. or 4762., O.R.C. or as otherwise required by state or federal law.

U.S. Social Security Number	_____									
Full Name (Use no initials)	Last _____ First _____ Middle _____ Suffix (Jr., II) _____									
Maiden Name or other names used (If none, enter "NONE")	Last _____ First _____ Middle _____									
	<table border="1"> <tr> <td align="center" colspan="2">Dates Used</td> </tr> <tr> <td align="center">mo/yr</td> <td align="center">mo/yr</td> </tr> <tr> <td>From: /</td> <td>To: /</td> </tr> <tr> <td align="center">mo/yr</td> <td align="center">mo/yr</td> </tr> <tr> <td>From: /</td> <td>To: /</td> </tr> </table>	Dates Used		mo/yr	mo/yr	From: /	To: /	mo/yr	mo/yr	From: /
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Current Home Address <u>IMPORTANT</u> Notify the Board office immediately, in writing, of any change in address	Number & Street _____ Apt. _____ City _____ State _____ Zip Code _____ Country _____									
Email Address	_____									
Telephone Number	<table border="1"> <tr> <td align="center">area code & number</td> <td align="center">area code & number</td> </tr> <tr> <td>Business: ()</td> <td>Home: ()</td> </tr> </table>	area code & number	area code & number	Business: ()	Home: ()					
area code & number	area code & number									
Business: ()	Home: ()									
Birth Date	<table border="1"> <tr> <td align="center">month/day/year</td> <td rowspan="2">Birth Place</td> <td align="center">City</td> <td align="center">State</td> <td align="center">Country</td> </tr> <tr> <td align="center">/ /</td> <td align="center">City</td> <td align="center">State</td> <td align="center">Country</td> </tr> </table>	month/day/year	Birth Place	City	State	Country	/ /	City	State	Country
month/day/year	Birth Place	City		State	Country					
/ /		City	State	Country						
High School	Name of School _____ City _____ Date of Graduation _____									
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female For statistics only (optional)									

PROFESSIONAL EDUCATION

Cosmetic Therapy School of Graduation	School Name			
	City	State	Country	
Dates Attended	From: mo/yr /	To: mo/yr /	Date Diploma Received or to be received	mo/day/yr / /

Other Cosmetic Therapy Schools Attended (If not applicable, enter "NONE")	School Name			
	City	State	Country	
Dates Attended	From: mo/yr /	To: mo/yr /	Reason degree not received at this school	

LICENSES IN THE UNITED STATES OR CANADA

List ALL states/provinces, whether the license is current or not, in which you are or have been licensed to practice cosmetic therapy or other health profession(s). Indicate the license number, date of issuance and the type of license (e.g., massage therapy, cosmetic therapy, etc.). If additional space is needed, please attach an extra sheet. (If none, enter "**NONE**")

State	Issue Date mo/yr	License No.	Type of License	License Current
	/			<input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____ <div style="text-align: right;">mo/yr</div>
	/			<input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____ <div style="text-align: right;">mo/yr</div>
	/			<input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____ <div style="text-align: right;">mo/yr</div>
	/			<input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____ <div style="text-align: right;">mo/yr</div>
	/			<input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____ <div style="text-align: right;">mo/yr</div>

Applicant Name (print clearly): _____

Date: _____

COSMETIC THERAPY RESUME OF ACTIVITIES

List **ALL** activities in chronological order for the last five years, using **MONTH** and **YEAR**. Time periods longer than thirty days **MUST** be documented. If you have been out of high school for less than five years, only list activities *starting with* high school graduation to the present time. **Be sure to use business addresses for all working time.** For any non-working time, you **MUST** state on the resume exactly what your activities were, such as "vacation" or "looking for work", as *well as your permanent home address*. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** If additional space is needed, please attach separate sheets.

From Month/Year / To Month/Year /	Employer or Non-working Activity Complete Street Address Number & Street City State/Country Zip Code	Position
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From Month/Year / To Month/Year /	Employer or Non-working Activity Complete Street Address Number & Street City State/Country Zip Code	Position
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From Month/Year / To Month/Year /	Employer or Non-working Activity Complete Street Address Number & Street City State/Country Zip Code	Position
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From Month/Year / To Month/Year /	Employer or Non-working Activity Complete Street Address Number & Street City State/Country Zip Code	Position
--	---	----------

Applicant Name (print clearly): _____

Date: _____

From Month/Year / To Month/Year /	Employer or Non-working Activity Complete Street Address Number & Street City State/Country Zip Code	Position
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From Month/Year / To Month/Year /	Employer or Non-working Activity Complete Street Address Number & Street City State/Country Zip Code	Position
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From Month/Year / To Month/Year /	Employer or Non-working Activity Complete Street Address Number & Street City State/Country Zip Code	Position
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From Month/Year / To Month/Year /	Employer or Non-working Activity Complete Street Address Number & Street City State/Country Zip Code	Position
--	---	----------

From Month/Year / To Month/Year /	Employer or Non-working Activity Complete Street Address Number & Street City State/Country Zip Code	Position
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Applicant Name (print clearly): _____

Date: _____

COSMETIC THERAPY ADDITIONAL INFORMATION QUESTIONS

If you answer "YES" to any of the following questions, **you** are **required** to furnish complete details, including date, place, reason and disposition of the matter. **All yes answers must be thoroughly explained on a separate sheet of paper.** Please note that some questions require very specific and detailed information. Make sure all responses are complete. A "yes" answer or failure to answer any questions truthfully could result in a denial of licensure. For definitions of key terms, please see #8 on the Application Instructions page.

(Please place a in the yes or no box)

		YES	NO
1.	Have you ever withdrawn or been terminated from any cosmetic therapy school, apprenticeship or course of instruction related to cosmetic therapy?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you ever resigned from a cosmetic therapy school, apprenticeship or course of instruction related to cosmetic therapy?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you ever been disciplined by a cosmetic therapy school, apprenticeship or course of instruction related to cosmetic therapy?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you ever been terminated from a position you held with any business, organization, association and/or institution, either private or public, involved in the practice of cosmetic therapy?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you ever resigned from a position you held with any business, organization, association and/or institution, either private or public, involved in the practice of cosmetic therapy?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you ever practiced, advertised, announced yourself as practicing or conducted an office for practicing cosmetic therapy while not holding a valid license from the State Medical Board of Ohio or from any other licensing agency?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you ever practiced, advertised, announced yourself as practicing or conducted an office for practicing cosmetic therapy without holding a required valid license, permit, certificate or registration from a municipality or township?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Has any licensing board or agency, including those in Ohio, ever denied you a certificate or license?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Has any licensing board or agency, including those in Ohio, ever refused you a renewal or reinstatement of a certificate or license?	<input type="checkbox"/>	<input type="checkbox"/>
10.	With respect to a professional license, have you ever been notified of any charges, allegations or complaints filed against you with any licensing agency, including those in Ohio?	<input type="checkbox"/>	<input type="checkbox"/>
11.	To your knowledge, are you the subject of an investigation by any licensing board or agency, including those in Ohio, as of the date of this application?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Has any licensing board or agency, including those in Ohio, revoked, suspended or restricted your license or placed you on probation?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Has any licensing board or agency, including those in Ohio, reprimanded, fined, disciplined, requested or accepted surrender of your license?	<input type="checkbox"/>	<input type="checkbox"/>

Applicant Name (print clearly): _____

Date: _____

		YES	NO
14.	<p>Have you ever been charged with, arrested for, convicted of, sentenced for, pled guilty or no contest to, or are there any charges pending against you for any felony, misdemeanor, or any offense other than a minor traffic violation? (DUI, DWI, OVI, Reckless Operation and any other offenses involving the use of alcohol or drugs are NOT minor traffic violations. Expunged records must be included. Arrests must be reported even if the charges were dismissed.)</p> <p>If the answer is yes, please complete and submit a Criminal Offense Information form for each incident. You must also provide certified copies of the police report/arrest record, the charges/ticket, the final court disposition and any other relevant documentation.</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>For questions 15-19, if you are less than 23 years of age, please do <u>not</u> include information prior to age 18</p>			
15.	<p>Do you currently have or have you had within the last five years, any medical condition, including but not limited to, bipolar disorder, schizophrenia, paranoia or any other psychotic disorder, which impaired or might reasonably impair your ability to practice cosmetic therapy safely and competently?</p> <p>If the answer is yes, please provide a letter from your treating physician that indicates your ability to practice cosmetic therapy safely and competently.</p>	<input type="checkbox"/>	<input type="checkbox"/>
16.	<p>Within the past five years, have you been admitted to or treated by any hospital or other in-patient or out-patient facility for any medical condition, including but not limited to, bipolar disorder, schizophrenia, paranoia or any other psychotic disorder, which impaired or might reasonably be considered to impair your ability to practice cosmetic therapy safely and competently?</p> <p>If the answer is yes, please provide a letter from your treating physician that indicates your ability to practice cosmetic therapy safely and competently.</p>	<input type="checkbox"/>	<input type="checkbox"/>
17.	<p>Do you currently have, or have you had within the past five years, a dependency on or have you abused any chemical substance(s) which impaired or might reasonably impair your ability to practice cosmetic therapy safely and competently?</p>	<input type="checkbox"/>	<input type="checkbox"/>
18.	<p>Within the past five years, have you engaged in the excessive or illegal use of any chemical substance(s), or received any in-patient or out-patient or individual therapy/treatment or been hospitalized for ongoing alcohol or drug abuse, or been arrested for driving under the influence?</p>	<input type="checkbox"/>	<input type="checkbox"/>
19.	<p>Within the past five years, have you refused a chemical substance screening test or have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug or alcohol level above .08% BAC?</p>	<input type="checkbox"/>	<input type="checkbox"/>
20.	<p>Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism or voyeurism?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>If you have authority to prescribe, please answer questions 21 a - d. All other applicants proceed to the signature line.</p>			
21.	<p>a. Are you currently registered with the Drug Enforcement Agency (DEA)?</p> <p>If yes, provide DEA number: _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>b. If you are not currently registered with the DEA, have you been registered in the past?</p> <p>If yes, provide DEA number(s): _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>c. Have you ever been denied a DEA registration?</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>d. Have you ever had a DEA registration restricted, limited, revoked or suspended?</p>	<input type="checkbox"/>	<input type="checkbox"/>

Applicant Name (print clearly): _____

Date: _____

**COSMETIC THERAPY
FORM 1 - CERTIFICATE OF RECOMMENDATION**

This form is to be completed by a resident of the state in which you are residing. They must be sufficiently acquainted with the applicant for at least **SIX** months. Relatives may not serve as recommenders. This form must be notarized by the recommender.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED
BLACK & WHITE PHOTOS WILL NOT BE ACCEPTED

I, _____, affirm that _____,
(recommender, print name legibly) (applicant, print name legibly)

has been known to me personally for _____ years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant.

I hereby recommend him/her for a license to practice Cosmetic Therapy in the State of Ohio.

Address of Recommender	Number & Street		Telephone Number (include area code)	
	City	State Zip Code		
Signature of Recommender (name stamps not accepted)				

PHOTOGRAPH

Applicant: Staple a recent passport-type size **COLOR** photo of yourself here; must have been taken within the last six months

(black & white photos will not be accepted)

Subscribed and sworn to before me this _____ day of _____, 20_____.

Notary Public Signature

Date Commission Expires

Signature of Applicant

Date Photo Taken: _____ / _____
month/year

NOTARY SEAL

**COSMETIC THERAPY
FORM 1 - CERTIFICATE OF RECOMMENDATION**

This form is to be completed by a resident of the state in which you are residing. They must be sufficiently acquainted with the applicant for at least **SIX** months. Relatives may not serve as recommenders. This form must be notarized by the recommender.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED
BLACK & WHITE PHOTOS WILL NOT BE ACCEPTED

I, _____, affirm that _____,
(recommender, print name legibly) (applicant, print name legibly)

has been known to me personally for _____ years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant.

I hereby recommend him/her for a license to practice Cosmetic Therapy in the State of Ohio.

Address of Recommender	Number & Street		Telephone Number (include area code)	
	City	State Zip Code		
Signature of Recommender (name stamps not accepted)				

PHOTOGRAPH

Applicant: Staple a recent passport-type size **COLOR** photo of yourself here; must have been taken within the last six months

(black & white photos will not be accepted)

Subscribed and sworn to before me this _____ day of _____, 20_____.

Notary Public Signature

Date Commission Expires

Signature of Applicant

Date Photo Taken: _____ / _____
month/year

NOTARY SEAL

**COSMETIC THERAPY
FORM 2 - CERTIFICATE OF EDUCATION**

Instructions to school: Please complete the form and return to the State Medical Board of Ohio at the above address. **Please note that form is not to be completed prior to graduation.** Also, submit a copy of the applicant's diploma.

This certifies that _____ received a diploma from
Name of Applicant, print legibly

_____ on _____
Name of Cosmetic Therapy School date of graduation (mo/day/yr)

I further certify that he/she has completed instruction in Cosmetic and that his/her instruction included: practical and theoretical instruction in Cosmetic and the following as related to Cosmetic: Anatomy, Physiology, Pathology, Ethics, Clinical Program, and Hygiene and such other subjects as the Board deems necessary and appropriate to Cosmetic. The course of instruction was for a period of not less than _____ months and minimum of _____ clock hours.

Dates of attendance _____ to _____
mo/day/yr mo/day/yr

SCHOOL SEAL

(If school has no seal, indicate and have form notarized)

Name (please print)

Signature of President, Dean or Secretary or their designee
(NAME STAMPS ARE NOT ACCEPTABLE)

Position

**COSMETIC THERAPY
AFFIDAVIT AND RELEASE OF APPLICANT**

The affidavit and release MUST be completed by **ALL** applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered as incomplete.

ss STATE OF: _____
 COUNTY OF: _____

I, _____, hereby certify under oath that I am the person named in this application for a license to practice Cosmetic Therapy in the State of Ohio; that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is neither refundable nor transferable.

I further state that by filing this application for a license to practice Cosmetic Therapy in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of Cosmetic Therapy. **I further authorize and consent to the State Medical Board of Ohio and its agents or representatives accessing and reviewing my confidential personal information to carry out their responsibilities for the State Medical Board of Ohio.** I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that my application for a license to practice Cosmetic Therapy in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to licensure being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for licensure and that any fee I submitted is neither refundable nor transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives and any person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency furnishing information, of any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

I further understand that issuance of a certificate to practice a limited branch of medicine or surgery in Ohio will be considered on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to denial of said certificate.

Signature of Applicant

Subscribed and sworn to before me this _____ day of _____ 20 _____

Signature of Notary Public

(NOTARY SEAL)

Date Commission Expires

**APPLICATION – CERTIFICATE TO PRACTICE COSMETIC THERAPY
CRIMINAL OFFENSE INFORMATION**

This form must be completed if you have responded yes to Additional Information Question #14. *Make additional copies of this form as needed.*

Name of Applicant (print clearly): _____

OFFENSE INFORMATION:

Date of Incident: _____

Location of Incident: _____
City State

Were you arrested: Yes No

If the incident was alcohol-related, did you submit to a breath, blood, urine or other test to determine the amount of alcohol in your body: Yes No

If yes, type of test and result: _____

What offense(s) were you charged with: _____

Were the charges amended: Yes No

If yes, what were the final charges: _____

DISPOSITION: Pending Charges Dismissed Charges Dropped
 Plea: _____ Specify Other: _____ Specify

You must provide a detailed written explanation of the event including a description of the event, what led up to the event and what was learned. This must be described in your own words. Do not reference attached documentation. If additional space is needed, attach a separate sheet. Submit copies of the police report/arrest record, a copy of the charges or ticket, a copy of the final court disposition and any other relevant documentation.

Applicant Signature

Date