



# State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: [www.state.oh.us/med/](http://www.state.oh.us/med/)

**RE: Cosmetic Therapy**

Dear Applicant:

The enclosed **REQUEST FOR APPLICATION FORM AND PRELIMINARY EDUCATION FORM** must be completed *in its entirety* in order for an application to be forwarded to you.

IF YOU HAVE PREVIOUSLY HELD AN OHIO LICENSE DO NOT COMPLETE THESE FORMS. CONTACT THE RECORDS DEPARTMENT AT (614) 728-3113.

Upon completion of these forms return them to the Board in order that we may determine the appropriate application and materials to forward to you. Any Request for Application Form or Preliminary Education form that is not completed properly will be returned.

Also enclosed is information regarding licensure eligibility. Please read these materials carefully.

If eligible an application will be sent to you within a week of receipt of the Request for Application form.

Attachments:

## **COSMETIC THERAPY ELIGIBILITY FOR LICENSURE**

Cosmetic Therapy means the permanent removal of hair from the human body through the use of electric modalities approved by the board for use in cosmetic therapy, and additionally may include the systematic friction, stroking, slapping and kneading or tapping of the face, neck, scalp, or shoulders.

### **BY EXAMINATION**

Ohio's examination for licensure to practice Cosmetic Therapy consists of a written exam and a practical demonstration. To be eligible for examination an applicant must:

- Hold a high school diploma or its equivalent.
- Apply for and obtain a certificate of preliminary education from the Board.
- Complete a course of instruction of not less than one year and a minimum of six hundred clock hours at an approved School of Cosmetic Therapy. Subjects include both practical and theoretical instruction as well as Anatomy, Physiology, Chemistry, Bacteriology, Electricity, Ethics; Clinical program and Hygiene and such other subjects as the Board deems necessary and appropriate to Cosmetic Therapy.
- Pass the Basic Science portion and Limited Branch portion of the examination by a score of seventy-five (75) or above. Test subjects include Anatomy, Physiology, Chemistry, Bacteriology, Hygiene and Diagnosis as appropriate to the limited branch of medicine as well as a practical demonstration.

### **BY ENDORSEMENT**

**OHIO DOES NOT PROVIDE FOR RECIPROCITY OR ENDORSEMENT. LICENSURE IN OTHER STATES DOES NOT IN ANY WAY ASSURE OR GUARANTEE LICENSURE IN OHIO. YOU MUST TAKE THE EXAMINATION FOR LICENSURE IN OHIO.**

### **SCHOOL APPROVAL**

Under Ohio law the State Medical Board must determine the standing of the schools, colleges, institutions, or individuals giving instruction in any of the limited branches of medicine. Standards for school approval are established under Rule 4731-1 Ohio Administrative Code. Copies of the Statutes and Rules may be obtained from the Board's website at [www.state.oh.us/med/](http://www.state.oh.us/med/).

The Board recognizes that registration; approval or licensing laws and standards of other states regulating limited branch schools may differ from Ohio laws and standards. Therefore, the Board may recognize out-of-state schools as institutions in good standing for purposes of admitting graduates from those schools for examination for licensure in Cosmetic Therapy providing the school has met the requirements set forth Rule 4731-1. If an application is received from an out-of-state graduate holding a diploma not previously approved, an effort will be made to gather adequate information concerning the educational experience by the forwarding of an application by the Board to the school of graduation. Information received will be evaluated by the Board to determine whether or not to approve the school.

Approval pursuant to this process may apply to other applicants from that school during the period of approval.

If information is not received from the school within six months, the Board may propose to deny the applicant. The applicant, if they so request, will then have an opportunity to present evidence of having met all requirements at a formal administrative hearing.

## **COSMETIC THERAPY REQUEST FOR APPLICATION FORM INSTRUCTIONS**

*(Please read and follow the instructions carefully)*

1. Complete the enclosed **COSMETIC THERAPY REQUEST FOR APPLICATION FORMS AND PRELIMINARY EDUCATION APPLICATION** in its entirety.
2. Submit a check or money order for **\$35.00** made payable to the **State Medical Board of Ohio**. Fees submitted are neither refundable nor transferable.
3. Have your high school of graduation forward directly to this Board your transcripts. Make sure the copy of your transcripts includes the following:
  - a. total number of credit hours earned
  - b. the date of graduation
  - c. your date of birth
  - d. either the school seal or the original signature of a school official  
*(original signatures only, name stamps will not be accepted)*

If your transcripts are not in English, a translation must also be submitted.

If you do not have a high school diploma, have the Department of Education submit an official transcript of your G.E.D. scores. G.E.D. Certificates are not acceptable in lieu of the transcript.

**NOTE: ISSUANCE OF A PRELIMINARY EDUCATION NUMBER IN NO WAY ASSURES YOU ADMITTANCE TO THE EXAMINATION.**

4. Submit a photocopy of your Cosmetic Therapy diploma.
5. Submit a transcript of your grades from your Cosmetic Therapy school of graduation. The transcript must include the total number of hours received.
6. Forward the enclosed Certificate of Education (Form 2) to the school where you completed your Cosmetic Therapy training. The form must be completed by the President, Dean, or Secretary of the school. This form must not be completed **prior** to graduation.
7. If you have changed your name, you must submit a photocopy of the appropriate legal document that 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 a translation.



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<b>FOR BOARD USE ONLY</b>			
<b>FEE: \$35.00</b>			
<b>BK:</b> _____	<b>PG:</b> _____	<b>LN:</b> _____	
<b>DATE:</b> _____		<b>PMT:</b> _____	

## COSMETIC THERAPY REQUEST FOR APPLICATION FORMS

*(Please type or print clearly)*

I hereby submit the following information in order to receive an application for Cosmetic Therapy licensure.

<b>Name:</b>	Last (Surname)	First	Middle	Suffix (Jr., II)
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<b>Address:</b>	Number & Street			
	City	State	Zip Code	Country

<b>Telephone:</b>	<b>Business:</b>	Area Code & Number (      )	<b>Home:</b>	Area Code & Number (      )
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<b>Birth Date:</b>	Mo/Day/Yr /   /	<b>Birth Place:</b>	City	State	Country
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## COSMETIC THERAPY EDUCATION

<b>Cosmetic Therapy School of Graduation:</b>	School Name		
	Street Address		
	City	State	Zip Code

<b>Dates Attended:</b>	<b>From:</b>	Mo/Day/Yr /   /	<b>To:</b>	Mo/Day/Yr /   /
------------------------	--------------	--------------------	------------	--------------------

<b>Number of Hours Completed:</b>		<b>Degree Received:</b>		<b>Date Received:</b>	Mo/Day/Yr /   /
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**OVER** ⇨

Other  
Cosmetic  
Therapy  
Schools  
Attended  
(If none,  
enter  
"NONE"):

School Name			
Street Address			
City	State	Zip Code	Country

Dates Attended:      From: Mo/Day/Yr  
/   /      To: Mo/Day/Yr  
/   /

Reason degree not received at this school:

**LICENSES IN THE UNITED STATES OR CANADA**

List ALL states/provinces in which you hold or have held a license to practice Cosmetic Therapy, **whether the license is current or not**. If additional space is needed, attach an extra sheet. (If none, enter "NONE")

STATE/PROVINCE	ISSUE DATE (MO/YR)	LICENSE NO.	LICENSE CURRENT		EXPIRE(S)
			YES	NO	
	/		<input type="checkbox"/>	<input type="checkbox"/>	
	/		<input type="checkbox"/>	<input type="checkbox"/>	
	/		<input type="checkbox"/>	<input type="checkbox"/>	
	/		<input type="checkbox"/>	<input type="checkbox"/>	

**CERTIFICATION**

I hereby certify that I am the person referred to in the foregoing Request for Application forms for Cosmetic Therapy and that the statements herein are strictly true in every respect.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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## COSMETIC THERAPY PRELIMINARY EDUCATION APPLICATION

Cosmetic  
Therapy  
School:

Applicants  
Full Name:

Last	First	Middle	Suffix (Jr., II)
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List below all names used (i.e., maiden, married) other than the name given above. Also, indicate the time period during which you used the name(s). If none, enter "NONE". If additional space is needed, attach separate sheets.

Name (Last, First, Middle)	Dates Used	mo/yr	mo/yr
	FROM	/	TO /
	FROM	/	TO /
	FROM	/	TO /

Complete  
Address:

Street Number & Name			
City	State	Zip Code	Country

Date  
of Birth:

mo/day/yr / /	Place of Birth:	City	State	Country
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High  
School of  
Graduation:

Name of High School		Date of Graduation:
City		

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

### FOR BOARD USE ONLY

### CERTIFICATE OF PRELIMINARY EDUCATION

NO: \_\_\_\_\_ DATE ISSUED \_\_\_\_\_

This is to certify that this applicant has met the preliminary education requirements for the study of Cosmetic Therapy in conformity with the Statutes of Ohio and the Rules and Regulations of the State Medical Board of Ohio.

\_\_\_\_\_  
Entrance Examiner

\_\_\_\_\_  
Secretary



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## COSMETIC THERAPY FORM 2 - CERTIFICATE OF EDUCATION

I am applying for a license to practice Cosmetic Therapy in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by my Cosmetic Therapy school of graduation. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed above.

### TO BE COMPLETED BY APPLICANT

Name	Last	First	Middle	Suffix (Jr., II)
Current Address	Number & Street			
	City	State	Zip Code	

I hereby authorize my cosmetic therapy school of graduation to furnish the information below to the State Medical Board of Ohio.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

### TO BE COMPLETED BY SCHOOL

This certifies that the above named applicant received a diploma from:

Name of School:	
School Address:	Street Address
	City State Zip Code Country

Dates of Attendance: 

Mo/Day/Yr / /
------------------

 to 

Mo/Day/Yr / /
------------------

 Graduated on: 

Mo/Day/Yr / /
------------------

Total Number of Hours Completed: 

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OVER ⇨

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

I further certify that he/she has completed instruction in Cosmetic Therapy and that his/her instruction included: practical and theoretical instruction in Cosmetic Therapy as well as Anatomy, Physiology, Chemistry, Bacteriology, Electricity, Ethics, Clinical Program, and Hygiene; and such other subjects as the Board deems necessary and appropriate to Cosmetic Therapy. The course of instruction was for a period of not less than one year and minimum of 600 clock hours.

School Accredited by:

Name of accrediting body
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Address of Accrediting Body:

Street Address			
City	State	Zip Code	Country

\_\_\_\_\_  
Signature of President, Dean or Secretary (*Name stamps not acceptable*)

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Position

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

**(NOTARY SEAL)**

\_\_\_\_\_  
Notary Public Signature

\_\_\_\_\_  
Date Commission Expires