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.
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: ____________________________________________

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)