

# Cosmetic and Laser Supervising Physician Survey

**Name** \_\_\_\_\_

**Business Address** \_\_\_\_\_  
\_\_\_\_\_

**Business Telephone Number** \_\_\_\_\_

**Name of Individuals for whom you provide supervision:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Name, address and telephone number of the facility where you provide supervision:**

*Name of Facility* \_\_\_\_\_

*Address* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Telephone Number* \_\_\_\_\_

**What cosmetic treatments are offered at the facility where you provide supervision?**

*Treatments* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Name, Address and Telephone Number of individual(s) who own the facility:**

Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone Number \_\_\_\_\_

**Do you maintain a separate medical office?**

Yes \_\_\_\_\_ a \_\_\_\_\_ NO \_\_\_\_\_ xx \_\_\_\_\_

**If yes, address and telephone number of your medical office:**

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone Number \_\_\_\_\_

**How many hours per week are you personally present at the facility where you provide supervision:**

Hours per week? \_\_\_\_\_

**Are prescriptive medical/cosmetic devices and products provided by medical personnel at the facility or spa?**

Yes \_\_\_x\_\_\_\_\_ No \_\_\_\_\_

*Thank you that completes the survey, Please review and submit your answers  
Submit mailto: [info@bom.idaho.gov](mailto:info@bom.idaho.gov)*