

REQUEST FOR LIVE SCAN SERVICE
Applicant Submission

ORI: A0391 Type of Application: (check one) ☐ Employment ☐ License, Certification, Permit ☐ Volunteer
Code Assigned by DOJ

Job Title or Type of License, Certification or Permit: _____

Agency Address Set Contributing Agency:

BOARD OF REGISTERED NURSING, DCA

Agency authorized to receive criminal history information

05753

Mail Code (five-digit code assigned by DOJ)

PO BOX 944210

Street No.

Street or PO Box

N/A

Contact Name (Mandatory for all school submissions)

SACRAMENTO

CA

94244-2100

City

State

Zip Code

()

N/A

Contact Telephone No.

Name of Applicant: _____

(Please print)

Last

First

MI

AKA's: _____

Last

First

CA Driver's License #: _____

DOB: _____ SEX: ☐ Male ☐ Female

Misc. No. APPLICANT MUST PAY

Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. N/A

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

Place of Birth: _____

N/A

Street or PO Box

SOC: _____

N/A

City, State and Zip Code

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service ☐ DOJ ☐ FBI

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A

Employer Name

N/A

Street No.

Street of PO Box

N/A

Mail Code (five digit code assigned by DOJ)

N/A

City

State

Zip Code

N/A

Agency Telephone No. (Optional)

Live Scan Transaction By: _____
Name of Operator

Date: _____

Transmitting Agency

ATI No.

Amount Collected/Billed

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