

SAMPLE FOR CERTIFICATION OF NURSE ASSISTANTS OR HOME HEALTH AIDES

REQUEST FOR LIVE SCAN SERVICE
Applicant Submission

ORI: A1226 Type of Application: Certification
Code assigned by DOJ

Job Title or Type of License, Certification, or Permit: Certified Nurse Assistant (CNA) or Home Health Aide (HHA)

Agency Address Set Contributing Agency:
Department of Health Services, L&C 03314
Agency authorized to receive criminal history information Mail Code (five-digit code assigned by DOJ)
Fingerprint Investigation Unit (leave blank)
Street No. Street or PO Box Contact Name (Mandatory for all school submissions)
1615 Capitol Avenue, MS 3301, P.O. Box 997416 () (leave blank)
City State Zip Code Contact Telephone No.
Sacramento CA 95899-7416

Name of Applicant: Your full name
(Please print) Last First MI
AKA's: Other names known as CDL No.: California Drivers License Number
Last First
(Check one)
DOB: Date of birth SEX: Male Female Misc. No.: BIL – Not applicable
Agency Billing Number (if applicable)
HT: Height WT: Weight Misc. No.: Your telephone number
Eye color: Color Hair color: Color Home Address: Your mailing address
POB: Place of birth Street or PO Box
SOC: Social security number (Mandatory by DHS) City, State and Zip Code

Your Number: Not applicable
OCA No. (Agency Identifying No.)
Level of Service DOJ FBI
If resubmission, list Original ATI No. Not applicable

Employer: (Additional response for Department of Social Services, DMB/CHP licensing, and Department of Corporations submissions only)
(Leave blank)
Employer Name
(Leave blank)
Street No. Street or PO Box Mail Code (five digit code assigned by DOJ)
()
City State Zip Code Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed