

REQUEST FOR LIVE SCAN SERVICE
Applicant Submission

ORI: A1226 Type of Application: License: (Choose one) Employment OR License
Code assigned by DOJ

Job Title or Type of License, Certification, or Permit: Adult Day Health Care

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)
ATCS, 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
Alias: Other names known as Driver's License No.: CA Drivers License number
Last First (Check one)
DOB: Your date of birth SEX: Male Female Misc. No.: BIL - Not applicable
HT: Your height WT: Your weight Agency Billing Number (if applicable)
Eye color: Your eye color Hair color: Your hair color Misc. No.: Your telephone number
Place of Birth: Your place of birth Home Address: (Applies only if Youth Org/HRA or Public Utility Submission)
SOC: Your social security number Your mailing address
Street or PO Box
City, State and Zip Code

Your Number: Facility name and, if known, license number
OCA No. (Agency Identifying No.)
Level of Service DOJ FBI
If resubmission, list Original ATI No. _____

Employer: (Additional response for agencies specified by statute.)
Facility name
Employer Name
Facility address (Leave blank)
Street No. Street or PO Box Mail Code (five digit code assigned by DOJ)
City State Zip Code () Facility telephone number
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator
Transmitting Agency _____ ATI No. _____ Amount Collected/Billed _____