

REQUEST FOR LIVE SCAN SERVICE - COMMUNITY CARE LICENSING

Applicant Submission

1. ORI: A0448			
2. Working Title: <i>(Check ✓ one)</i>			
<input type="checkbox"/> Adult Resident other than Client <input checked="" type="checkbox"/> Employee <input type="checkbox"/> License, Certification, Applicant <input type="checkbox"/> Volunteer			
3. Authorized Applicant Type - Enter from list on Page 2, "DOJ Abbreviated CCLD Facility Type." Family Childcare			
4. Agency Address Set Contributing Agency:			
CA Dept of Social Services		03502	
Agency authorized to receive criminal history information		Mail Code <i>(five-digit code assigned by DOJ)</i>	
PO BOX 944243		Mail Station 9-15-62	
Street No.		Street or PO Box	
Sacramento,		CA	
City		State	
94244-2430		N/A	
Zip Code		Contact Telephone No.	
5. Applicant Information:			
Name of Applicant: <i>(Please print)</i> _____			
LAST		FIRST MI	
AKA's: _____		CDL No. _____	
LAST		FIRST	
DOB: _____		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	
HT: _____		WT: _____	
EYE Color: _____		HAIR Color: _____	
POB: _____		Misc. No. BIL - _____	
SOC: _____		Misc. No.: _____	
(See Privacy Statement on Page 4)		AGENCY BILLING NUMBER <i>(IF APPLICABLE)</i>	
		ALIEN REGISTRATION, OUT OF STATE DRIVER'S LICENSE OR I.D.	
		Home Address: <i>(All applicants must complete)</i>	
		STREET OR PO BOX	
		CITY, STATE AND ZIP CODE	
6. Facility Number: <u>013414483</u>			
Level of Service <input checked="" type="checkbox"/> DOJ <input checked="" type="checkbox"/> FBI			
If resubmission for fingerprint quality (select R2), list Original ATI No. _____			
7. Employer: <i>(Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)</i>			
Deborah Bishop			
Employer Name			
4197 Bidwell Dr.			
Street No.		Street or PO Box	
Fremont		CA	
City		State	
		94538	
		Zip Code	
		Mail Code <i>(five digit code assigned by DOJ)</i>	
		(510)299-1354	
		Agency Telephone No. <i>(Optional)</i>	
8.			
Live Scan Transaction Completed By: _____ Date _____			
Name of Operator			
Transmitting Agency		LSID#	
		ATI No.	
		Amount Collected/Billed	