



REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A1924 Occupational Thpy 144 BPC
 ORI (Code assigned by DOJ) Authorized Applicant Type
 OCCUPATIONAL THERAPIST OCCUPATIONAL THERAPY ASSISTANT
 Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:
BOARD OF OCCUPATIONAL THERAPY, DCA **07039**
 Agency Authorized to Receive Criminal Record Information Mail Code (five-digit code assigned by DOJ)
2005 EVERGREEN STREET, STE 2250 **CUSTODIAN OF RECORDS**
 Street Address or P.O. Box Contact Name (mandatory for all school submissions)
SACRAMENTO **CA** **95815** **(916) 263-2294**
 City State ZIP Code Contact Telephone Number

Applicant Information:

Last Name _____		First Name _____	Middle Initial _____	Suffix _____
Other Name (AKA or Alias) Last _____		First _____	Suffix _____	
Date of Birth _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Driver's License Number _____		
Height _____	Weight _____	Eye Color _____	Hair Color _____	
Place of Birth (State or Country) _____	Social Security Number _____		Billing Number APPLICANT PAYS ALL FEES (Agency Billing Number)	
Home Address Street Address or P.O. Box _____	Misc. Number _____ (Other Identification Number)		City _____ State _____ ZIP Code _____	

Your Number: RN # _____ Level of Service: DOJ FBI
OCA Number (Agency Identifying Number)

If re-submission, list original ATI number: _____
 (Must provide proof of rejection) Original ATI Number _____

Employer (Additional response for agencies specified by statute):
THIS SECTION IS NOT APPLICABLE **N/A**
 Employer Name Mail Code (five digit code assigned by DOJ)
N/A **N/A**
 Street Address or P.O. Box **N/A**
N/A **N/A** **N/A** **N/A**
 City State ZIP Code Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator _____	Date _____
Transmitting Agency _____	ATI Number _____
LSID _____	Amount Collected/Billed _____



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Applicant Information:

Last Name _____ Other Name (AKA or Alias) Last _____ Date of Birth _____ Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Height _____ Weight _____ Eye Color _____ Hair Color _____ Place of Birth (State or Country) _____ Social Security Number _____ Home Address Street Address or P.O. Box _____	First Name _____ Middle Initial _____ Suffix _____ First _____ Suffix _____ Driver's License Number _____ Billing Number APPLICANT PAYS ALL FEES <small>(Agency Billing Number)</small> Misc. Number _____ <small>(Other Identification Number)</small> City _____ State _____ ZIP Code _____
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N/A _____ City	N/A _____ State
N/A _____ ZIP Code	N/A _____ Telephone Number (optional)

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