REQUEST FOR LIVE SCAN SERVICE Applicant Submission

ORI: A0391 Type of Application: (check one)	mployment □License, Certification, Permit □Volunteer
Job Title or Type of License, Certification or Permit:	
Agency Address Set Contributing Agency: BOARD OF REGISTERED NURSING, DCA	05753
BOARD OF REGISTERED NURSING, DCA Agency authorized to receive criminal history information	
PO BOX 944210	N/A
Street No. Street or PO Box	Contact Name (Mandatory for all school submissions)
SACRAMENTO CA 94244-2100	() N/A Contact Telephone No.
City State Zip Code	Contact Telephone No.
Name of Applicant: (Please print) Last	First MI
(Piease piiit) Last	FIISL
AKA's:	CA Driver's License #:
Last First	
DOB: SEX:	Micc No APPLICANT MUST PAY
DOB: SEA	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)
	N/A
Place of Birth:	Street or PO Box
SOC:	N/A
	City, State and Zip Code
Your Number:	
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 lic	censing and Department of Corporations submissions only)
N/A	beliating, and Department of Corporations Submissions Study,
Employer Name	
N/A	N/A
Street No. Street of PO Box	Mail Code (five digit code assigned by DOJ
N/A	N/A
City State Zip Code	Agency Telephone No. (Optional)
Live Scan Transaction By:	Date:
Name of Operator	Date.
Transmitting Agency ATI No.	Amount Collected/Billed

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