

REQUEST FOR LIVE SCAN SERVICE
Applicant Submission

ORI: <u>AO434</u> <small>Code assigned by DOJ</small>	Type of Application: <u>License, Certification, Permit</u>
Job Title or Type of License, Certification or Permit: <u>Doctor of Podiatric Medicine</u>	

Agency Address Set Contributing Agency: <u>Board of Podiatric Medicine</u>		<u>03802</u> <small>Mail Code (five digit code assigned by DOJ)</small>	
<u>2005 Evergreen Street, Suite 1300</u> <small>Street No. Street or P.O. Box</small>		<u>Bethany DeAngelis</u> <small>Contact Name (Mandatory for all school submissions)</small>	
<u>Sacramento</u> <small>City</small>	<u>CA</u> <small>State</small>	<u>95815</u> <small>Zip Code</small>	<u>(916) 263-2649</u> <small>Contact Telephone No.</small>

Name of Applicant: _____ <small>(please print) Last First MI</small>	
Alias: _____ <small>Last First</small>	Driver's License No. _____
Date of Birth: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Misc. No. BIL- <u>BIL - 100026</u> <small>Agency Billing Number (if applicable)</small>
Height: _____ Weight: _____	Misc. No: _____
Eye Color: _____ Hair Color: _____	Home Address: <u>N/A</u> <small>Street or P.O. Box</small>
Place of Birth: _____	<u>N/A</u> <small>City, State and Zip Code</small>
SOC# _____	

Your Number: <u>BPM</u> <small>OCA No. (Agency Identifying No.)</small>	Level of Service <input checked="" type="checkbox"/> DOJ <input checked="" type="checkbox"/> FBI
If resubmission, list Original ATI No. _____	

Employer: (Additional response for agencies specified by statute) <u>N/A</u>	
Employer Name _____	
<u>N/A</u> <small>Street No. Street or P.O. Box</small>	<u>N/A</u> <small>Mail Code (five digit code assigned by DOJ)</small>
<u>N/A</u> <small>City State Zip Code</small>	<u>() N/A</u> <small>Agency Telephone No. (optional)</small>

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

REQUEST FOR LIVE SCAN SERVICE
Applicant Submission

ORI: A0434 Type of Application: License, Certification, Permit
Code assigned by DOJ

Job Title or Type of License, Certification or Permit: Doctor of Podiatric Medicine

Agency Address Set Contributing Agency:
Board of Podiatric Medicine 03802
Agency authorized to receive criminal history information Mail Code (five digit code assigned by DOJ)

2005 Evergreen Street, Suite 1300 Bethany DeAngelis
Street No. Street or P.O. Box Contact Name (Mandatory for all school submissions)

Sacramento CA 95815 (916) 263-2649
City State Zip Code Contact Telephone No.

Name of Applicant: _____
(please print) Last First MI

Alias: _____ Driver's License No. _____
Last First

Date of Birth: _____ Sex: Male Female Misc. No. **BIL-** BIL - 100026
Agency Billing Number (if applicable)

Height: _____ Weight: _____ Misc. No: _____

Eye Color: _____ Hair Color: _____ Home Address: N/A
Street or P.O. Box

Place of Birth: _____ N/A
City, State and Zip Code

SOC# _____

Your Number: _____ Level of Service DOJ FBI
OCA No. (Agency Identifying No.)

If resubmission, list Original ATI No. _____

Employer: (Additional response for agencies specified by statute)
N/A

Employer Name _____

N/A N/A
Street No. Street or P.O. Box Mail Code (five digit code assigned by DOJ)

N/A () N/A
City State Zip Code Agency Telephone No. (optional)

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

Transmitting Agency _____ ATI No. _____ Amount Collected/Billed _____

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Job Title or Type of License, Certification or Permit: <u>Doctor of Podiatric Medicine</u>	

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<u>Sacramento</u> <u>CA</u> <u>95815</u> <small>City State Zip Code</small>	<u>(916) 263-2649</u> <small>Contact Telephone No.</small>	

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