PUBLIC HEALTH DIVISION
Oregon Medical Marijuana Program

# Criminal Background Check Request Form

| | | | |
|---|---|---|---|
| Name *(Last, first, middle)* | Date of birth *(mm/dd/yy)* | | Gender<br>☐ Male ☐ Female |
| All other names used *(Last, first, middle; include maiden name)* | | | Social Security number *(SSN)** |
| Mailing address *(Street/apartment number)* | | | Driver license, military or state ID number: |
| City | State | ZIP | Home/message/phone |
| Home street address *(if different than mailing address)* | | | Cell phone |
| City | State | ZIP | Email address |
| Business name | | Business city | MMD/MMPS number |

*Providing your SSN is voluntary. The Oregon Health Authority (OHA) requests the SSN to identify the person during a criminal records check.

Have you ever been charged, arrested and/or convicted of a crime involving controlled substances?

☐ Yes ☐ No

If yes, list all charges, arrests and/or convictions involving controlled substances and the outcome regardless of how long ago. Please include the type of controlled substances involved.

**Attach additional pages if needed.**

| | Date *(or estimate)* | List each charge, arrest or conviction | Controlled substances | County | State | Outcome |
|---|---|---|---|---|---|---|
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |

During the last five years, have you been outside of Oregon for 60 days or more in a row?

☐ Yes ☐ No

If yes, complete the following for each residence in the past five years.

**Attach additional pages if needed.**

| | Date *(mm/dd/yy)* | | City | State | Country | Name(s) used at this residence |
|---|---|---|---|---|---|---|
| | Start | End | | | | |
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |

When fingerprints are electronically transmitted without a fingerprint card, please attach a completed copy of the Request for Transmission of Electronic Regulatory Fingerprints form (https://public.health.oregon.gov/DiseasesConditions/ChronicDisease/MedicalMarijuanaProgram/Documents/form/Livescan-Trans-Form.pdf), and note the following information:

Name of transmitting agency _____ Date / /

By signing below, I certify I am the person listed and the information on this form is complete and correct. I understand I will need to have a national criminal records check including fingerprints. My signature authorizes the OMMP program and the Department of Human Services/Oregon Health Authority Background Check Unit, to request and receive any juvenile, police, court or investigation reports needed to complete this background check. If the information found disqualifies me, I will be told about how to challenge the background check. I understand if I provide false or incomplete information, my application may be returned as incomplete or denied. I understand the background check may be repeated during the time the dispensary or processing site is registered.

Signature _____ Date / /

**Mail this completed form and fingerprint card (*unless electronically transmitted*) to:**

**OHA/OMMP**
**P.O. Box 14450**
**Portland, OR 97293-0450**