

# Request for Transmission of Electronic Regulatory Fingerprints

**Information for Livescan Operator** Please note: The Transmitting Agency will NOT be charged or billed for this Background Check.

Requesting Agency ORI: **OR0260BNE**

Requesting Agency Billing Code: **83300-41801-5004**

Reason Fingerprinted: **OBNE LICENSURE ORS 685.195**

OCA: **NAEX**

TOT (Type of Transaction): **NFUF** Retained: **N** To properly transmit the fingerprint card, the Information provided  
On this form must be entered into the Livescan prior to sending to OSP

## Requesting Agency Information (the agency requesting background check)

Agency Name: **Oregon Board of Naturopathic Medicine**

Authorizing Statute: **ORS 685.195**

Contact Person: **Anne Walsh**

Job Title: **Executive Director**

Phone Number: **971-673-0193 / 971-673-0194**

**Attention Requesting Agencies:** Complete the first two sections on this form and provide form to your background check Applicant along with any instructions specific to your agency for background check processing. Contact OSP CJIS Regulatory Supervisor with any questions **503-378-3070**.

**Attention Livescan Operator:** Applicant fingerprints must be transmitted using Requesting ORI and Billing Code as provided on each individuals form; call AFIS if sent in error. After prints are sent, complete the bottom of this form and return to applicant.

## Applicant Information

Name: \_\_\_\_\_  
(Please Print) Last First Middle

Alias or Maiden: \_\_\_\_\_  
Last First Middle

Additional Alias: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_ Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
mm/dd/yyyy feet inches pounds

Race:  Asian or Pacific Islander  Black/African-American  American Indian or Alaska Native  White/Hispanic

Eye Color:  BLK  BLU  BRO  GRY  GRN  HAZ  XXX (Unknown)

Hair Color:  BLK  BLN  BRO  GRY  RED/AUBURN  SDY  WHT  XXX (Bald or Unknown)

Place of Birth: \_\_\_\_\_ (If born in USA, enter the State, if outside USA, enter the Country)

Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ (The identification process will benefit from this information. However, it is not required that the SSN be provided)

**THIS FORM IS TO BE RETAINED BY THE APPLICANT AT TIME OF FINGERPRINTING FOR FUTURE REFERENCE**

Live Scan Transaction Completed By: \_\_\_\_\_ Transmission Date & Time \_\_\_\_\_  
Name of Livescan Operator

Transmission TCN (13digit # starting with the Livescan 5 digit ID#) \_\_\_\_\_

Transmitting Agency: \_\_\_\_\_ Phone \_\_\_\_\_  
Name of transmitting Agency