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**: OR024CRU0 Requesting Agency **Billing Code**: MMD-OHA

Reason Fingerprinted: License/Certificate/Permit

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: OHA MEDICAL MARIJUANA DISPENSARY PROGRAM Authorizing Statute: 475.314; 475.338; 181.534

Contact Person: MMD Staff

Phone Number: (971) 673-1234

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. If fingerprints are for reprints due to previously rejected fingerprints, use *TCR Reprint Form*. 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 individual's 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: _____ (mm/dd/yyyy) Sex: ☐ Male ☐ Female Height: ____ (feet) ____ (inches) Weight: _____ (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: _____ (Name of Livescan Operator) Transmission Date & Time: _____

Transmission TCN (13digit # starting with the Livescan 5 digit ID#): _____

Transmitting Agency: _____ (Name of transmitting Agency) Phone: _____