

TRUSTLINE FINGERPRINTING FORM

REQUEST FOR LIVE SCAN SERVICE FOR TRUSTLINE REGISTRY APPLICANTS

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

1.	ORI: A1157 Applicant Type: <input type="checkbox"/> TrustLine Registry Employee Applicant Submission <input type="checkbox"/> TrustLine Registry Volunteer	ORIGINAL-Requesting Agency COPY-Applicant
2.	Working Title: Child Care Provider (Health & Safety Code 1596.603)	
3.	Agency Address Set Contributing Agency:	
	CA Dept of Social Services	03502
	Agency authorized to receive criminal history information	Mail Code (<i>five-digit code assigned by DOJ</i>)
	744 "P" Street	N/A
	Street No. Street or PO Box	Contact Name (<i>Mandatory for all school submissions</i>)
	Sacramento CA 95814	() N/A
	City State Zip Code	Contact Telephone No.
4.	Applicant Information:	
	Name of Applicant: (Please print) _____	
	<small>LAST</small>	<small>FIRST</small> <small>MI</small>
	AKA's _____	CDL No. _____
	<small>LAST</small> <small>FIRST</small>	
	DOB: _____ SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	Misc. No. BIL- NA
		<small>AGENCY BILLING NUMBER (IF APPLICABLE)</small>
	HT: _____ WT: _____	Misc. No.: _____
		<small>ALIEN REGISTRATION, OUT OF STATE DRIVER'S LICENSE OR ID.</small>
	POB: _____	Home Address: (<i>All applicants must complete</i>)
	HAIR: _____ EYE: _____	_____
		<small>STREET OR PO BOX</small>
	SOC No. _____	_____
	<small>(See Privacy Statement on next page)</small>	<small>CITY, STATE AND ZIP CODE</small>
5.	Your Number: <u>TLR</u>	Level of Service <input checked="" type="checkbox"/> DOJ <input checked="" type="checkbox"/> FBI
	If resubmission, list Original ATI No. _____ (must present proof of rejection)	
6.	NOTE: NOT APPLICABLE FOR TRUSTLINE APPLICANTS	
	Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)	
	N/A	
	Employer Name	
	N/A	N/A
	Street No Street or PO Box	Mail Code (<i>five-digit code assigned by DOJ</i>)
	N/A	N/A
	City State Zip Code	Agency Telephone No. (<i>Optional</i>)
7.	Live Scan Transaction Completed By: _____ Date _____	
	<small>NAME OF OPERATOR</small>	
	Transmitting Agency	Amount Collected/Billed
	LSID#	ATI No.