



LIVESCAN ELECTRONIC FINGERPRINTING

FINGERPRINTING APPLICANT INFORMATION

ORI/VECH # _____ (Required) OCA # _____

REASON FOR PRINTS: _____

LAST NAME: _____ FIRST NAME: _____

MIDDLE NAME: _____ MAIDEN NAME: _____

SSN: _____ DATE OF BIRTH: _____

(Required by DCF & AHCA)

(YYYYMMDD)

EMAIL: _____ @ _____

CELL PHONE # _____

PLACE OF BIRTH (State or Country): _____

RESIDENCE ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

RACE: _____ EYE COLOR: _____ HAIR COLOR: _____

GENDER: MALE/FEMALE/UNKNOWN HEIGHT: _____ WEIGHT: _____

I _____ affirm that the above information pertains
(Print Name) to me, is my personal information, and is true and correct to
the best of my knowledge. I understand that any errors or omissions may result
in additional fees from FDLE if resubmission is required.

SIGNED: _____ DATE: _____

COMPANY NAME: _____

COMPANY ADDRESS: _____