Fingerprint Fee Applicant Consent Release

Carlinville Office
227 East 1st South Street
Carlinville, IL 62626
Ph (217) 854-4016
Fax (217) 854-2032

Jerseyville Office
201 W Exchange Street
Jerseyville, IL 62052
Ph (618) 498-5541
Fax (618) 498-5543

Applicant Last Name: ___________________________ First Name: __________________________ MI: _________

SS#: __________ - _______ - _____________ Date of Birth (XX/XX/XXXX): ________/________/____________

Street Address: ____

City: ____ State: ___________ Zip Code: ____________________

State of birth (Country, if born outside of the US): ____________Phone Number: (_______) _______ - __________________

Gender: __________ Race: __________ Height: __________ Weight: __________ Hair Color: __________ Eye Color: __________

Email Address: ____

Please circle one of the following Purposes for Fingerprinting:

Health Care (Home Health/Nursing Home) (IDFPR) Registered Nurse (IDFPR) LPN (IDFPR)

Teacher (Full Time) Teacher (Substitute) Paraprofessional School Bus Driver Coaching

Janitorial Office School Volunteer Video Gaming(IGB) Cannabis Mandatory Reporting

Conceal Carry-Applicant Conceal Carry-Instructor (CCI) Other:______________________________________

Are you being fingerprinted as a requirement of employment? YES NO

If yes, what is the name of the requesting agency?____

By signing below, I acknowledge and hereby authorize the release of any criminal history record information that may exist regarding me from any agency, organization, institution, or entity having such information on file. I am aware and understand that my fingerprints may be retained and will be used to check the criminal history record information files of the Illinois State Police and/or the Federal Bureau of Investigation, to include but not limited to civil, criminal and latent fingerprint databases. I also understand that if my photo was taken, my photo may be shared only for employment or licensing purposes. I further understand that I have the right to challenge any information disseminated from these criminal justice agencies regarding me that may be inaccurate or incomplete pursuant to Title 28 Code of Federal Regulation 16.34 and Chapter 20 ILCS 2630/7 of the Criminal Identification Act.

Applicant Signature: ____

Date of Signature: ________/________/____________

IMPORTANT: If this appointment is for a school district/business that will be making payment there must be an authorized signature here:

School Dist /Business Name: ____

ORI # ____ Authorized by: ____

Applicant Last Name: ______________________________ First Name: ____________________________

Official ROE #40 Office Use Only:

Ref #: ____

Appointment Date:

____

TCN # LS11122L_______________________________ or

Appointment Time:

_______:________ AM / PM

TCN # LS11104L_______________________________

Technician Signature: ____

Applicant Identification Expiration date: ______ / ______ / __________

Paid in Full: _____-______-____________ CASH CHECK

Billing Information:

Name of Payee: ________________________________ Invoice via: FIRM SYSTEMS or ROE 40

*Payment (Circle One): Billing ORI: _______________________________

SELF-PAY EMPLOYER INSTITUTON