

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 check one of the following Purposes for Fingerprinting:

- | | | | | | |
|---|--------------------|--------------------------------|--------------------|------------|--------|
| Teacher | Substitute Teacher | Paraprofessional | School Bus Driver | Janitorial | Office |
| Kitchen | Coaching | School Volunteer | Video Gaming (IGB) | Cannabis | |
| Healthcare (Home Health/Nursing Home [IDFPR]) | | Registered Nurse [IDFPR] | LPN [IDFPR] | | |
| 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 ROE 40

*Payment (Check One): Billing ORI: _____

SELF-PAY EMPLOYER INSTITUTION