OFFICE ONLY

Payment Method: _____

Florida Fingerprint Consent Form

AGENCY LICENSE # 262.000033

Person Fingerprinted: _____

ORI#_____

Medical Submission? ☐ **Yes** ☐ **No**

Example: Physician's License or Nurse
If Yes, please send a clean photo of your head, from top of shoulders to top of head, to fingerprinting@itouchbiometrics.com

Email Address:_____

Phone Number:_____

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 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.

Sign and Date on day of appointment. Or before sending in mail

X_____Date: _____

For Office Use Only:

Applicant TCN# 80CD28000000000000__ __ __ __ State ID _____

To check the status of your Florida transmission, please visit the FDLE website at https://cchinet.fdle.state.fl.us/search/app/tcnlookup?2 and input your TCN (located above) or call FDLE at (850) 410-8161

Technician:_____

Phone: 847-706-6789 ***10am-4pm, Monday-Friday*** ***Fax: 630-912-2111***