

# Family Resource Center

## Fingerprint Applicant Form

Please Provide The Following Information (Please Print Clearly).

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Place of Birth: ( State or Country if outside USA): \_\_\_\_\_

### ORI-ILL14145S

Type of Check Needed: (circle one)		
<b>State Only</b>	<b>FBI Only</b>	<b>State and FBI</b>
\$43.75	\$51.15	\$57.45

(DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE ONLY)

TCN# \_\_\_\_\_ Date Printed \_\_\_\_\_