

Assistant Counselor Job Description

Job Requirements

Activities are planned in a camp setting for a group (cabin) of 5-10 children aged 7 - 14 years old who are affected by a bleeding disorder. Assistant Counselor's roles are:

- ▶ To participate under the supervision of the Camp Directors and Head Cabin Counselor in planning and implementing activities in the safest manner possible.
- ▶ To be a positive adult role model.
- ▶ To actively interact with the children to promote and encourage their personal growth.

Requirements

Applicant must be 18 - 20 years old by June 18, 2011. Prior attendance at Camp Hemotion or work with children in a recreational or educational setting is desirable. Must have an interest in leadership skills and willingness to learn and understand organizational skills and group dynamics. Must have an ability for and an interest in leading a variety of recreational activities including sports, games, creative arts, swimming and environmental education. Must have an ability to perform under stress and pressure while remaining flexible. Must have a genuine interest in working with people.

Job Overview

1. As part of a group, plan and conduct recreational activities for 7-14 year olds in a camping program.
2. Stay with your assigned group at all times unless previous arrangements have been made with a Head Cabin Counselor.
3. In leading activities, encourage children to take responsibility for themselves (i.e., clean up after themselves).
4. Follow all HFNC and program policies, as well as legal guidelines.
5. Attend staff meetings and all staff training events, including **training session that begins on Saturday, June 18, 2011**
6. Follow all Camp Oakhurst Policies and Guidelines.
7. Report all accidents to the Camp Director.
8. Assist in maintenance of the camp as needed. This includes sweeping and mopping of floors, wiping off of table, counter tops, putting supplies away, setting up and breaking down equipment.
9. Report to all camp events and meals on time.

Public Relations

1. Maintain a healthy relationship with all camp personnel. Attempt, with the Head Cabin Counselor, to correct any minor behavior problems before they become serious problems.
2. Act in a courteous and friendly manner when leading the group in camp. Maintain a nonabrasive relationship with all other cabin groups.

Personal Development

1. Develop skills in planning and implementing activities with children.
2. Be prepared to receive feedback and support from anyone at camp.
3. Maintain a positive and open outlook. Try to work out problems with the rest of the staff. Be sensitive to other staff members' needs.
4. Report and discuss all ongoing problems and concerns with a Head Cabin Counselor.
5. Be a positive role model for the children. Reward and encourage their good behavior with attention and affection.

6400 Hollis Street, Suite 6
Emeryville, CA 94608
(510) 658-3324 Phone

CAMP HEMOTION 2011
ASSISTANT COUNSELOR APPLICATION

For identification
purposes please
attach your
photo here.

General Information (ALL APPLICANTS)

Applicant's First Name _____ Last Name _____

Address _____ City _____ ST _____ Zip _____

If in school, name of school _____ Grade Level in Sep. '10 _____

Birthdate _____ Age _____ Height _____ Weight _____ M F

E-Mail Address _____ Cell Phone _____

Day Phone _____ Eve Phone _____

State ID/Driver's license # _____ Social Security # _____

If your application is accepted, may we place your contact information on the camp roster? Yes No

Work Experience (ALL APPLICANTS)

If employed, current employer	Job Title
Volunteer Experience _____	

References (Provide 3 personal, school, and/or employment references. **Do not list relatives**) (ALL APPLICANTS)

Last Name	First Name	Relationship	Phone
Last Name	First Name	Relationship	Phone
Last Name	First Name	Relationship	Phone

Emergency Contact Info (ALL APPLICANTS)

Last Name	First Name	Relationship
Day Phone	Evening Phone	Cell Phone

Siblings (i.e. Brothers, Sisters, Cousins) also attending camp (ALL CAMPERS)

First and Last Name	Age	First and Last Name	Age

Transportation (ALL APPLICANTS)

Please choose the departure location where you will depart for camp and the arrival location where you will be dropped off after camp. You will receive the exact time for your chosen location in your camper confirmation letter.

Pickup for camp location Emeryville Amtrak Station Sacramento Amtrak Station Fresno Amtrak Station

Return from camp location UCSF Oakland Children's Hospital Lucile Packard Children's Hospital Davis/Sacramento Medical Center Stockton Modesto Madera Children's Hospital

Patient Provided Medical History

6400 Hollis Street, Suite 6
Emeryville, CA 94608
(510) 658-3324 Phone

Name: _____

Name of Hemophilia Treatment Center & Physician (ALL APPLICANTS)	
Affected Assistant Counselor	Unaffected Assistant Counselor
Hematologist	Physician
Hemophilia Treatment Center	Institution
Address	Address
Phone	Phone

Immunization Dates (Complete below or include copy of Immunization Records) (ALL APPLICANTS)

Diphtheria/Pertussis/Tetanus _____ / _____ / _____ / _____ / _____

Tetanus Booster _____ MMR _____ / _____

Hepatitis A _____ / _____ Hepatitis B _____ / _____ / _____

Have you had chicken pox vaccine? Yes _____ Date _____ No _____

Have you had chicken pox disease? Yes _____ Date _____ No _____

Was this diagnosed by a physician? Yes _____ No _____ Verified by titer? Yes _____ No _____

Other Medical Conditions (ALL APPLICANTS)

ADD/ADHD Allergies Asthma Hay Fever Trouble Sleeping Other

Drug / Clotting Factor Allergies (ALL APPLICANTS)

Food Allergies: Name _____ Type of reaction _____ Name _____ Type of reaction _____

Drug / Clotting Factor: Name _____ Type of reaction _____ Name _____ Type of reaction _____

Factor Therapy	Dose of Factor	Frequency
Prophylactic Therapy		
Minor bleeds/soft tissue of muscle		
Joint bleeds		
Major bleeds		
Trauma or Head Injury		

Medications (ALL APPLICANTS)

Clotting Factor Brand Name? (if used)	Dose	Frequency
Other medications including over-the-counter	Dose	Frequency
Vitamins	Dose	Frequency

INDEMNIFICATION

Authorization to Provide Emergency Medical Treatment (ALL APPLICANTS)

Name: _____ D.O.B. _____

I hereby authorize the Medical Director of Camp Hemotion or such designee or designees as the Medical Director may appoint, to provide for the giving of emergency medical care or treatment, including medicines, immunizations, x-rays, tests, dental and minor surgical treatment, hospitalization, general anesthesia or other medical treatment as may be appropriate while I am in the care of Camp Hemotion. I understand that my information may be shared with/released to appropriate personnel for the purpose of treatment (including, but not limited to camp staff, referral centers and/or insurance companies). I further agree that this authorization includes the administration of all prescribed medications and treatments previously listed in this application and shall be effective until revoked.

X _____
 Your Signature Address
(SIGNATURE IS MANDATORY)

 Print Name Date City State Zip Tel

Insurance Information - MANDATORY (ALL APPLICANTS)	
Name of Insurance Company	If MediCal, specify number
Address	
Phone Number	
Policy Number or CIN#	If group insurance, specify company
Prescription plan (Co, ID#)	Name of primary person insured

Indemnification / Photo Release / Educational Program Permission (ALL APPLICANTS)

CONSENT TO PHOTOGRAPH

I hereby authorize the Hemophilia Foundation of Northern California to photograph me in connection with my presence at Camp Oakhurst. The photograph(s) may appear in hospital, Hemophilia Foundation, and/or public newspaper camp publicity.

Yes No

INDEMNIFICATION

I agree to hold harmless, indemnify and forever discharge the Hemophilia Foundation of Northern California, the hemophilia treatment centers, Camp Oakhurst, their employees or agents any claims which may arise as a result of or in connection with my participation in this camp or its activities. This includes any representatives acting on my behalf or on the behalf of my estate.

DURATION OF STAY

I hereby acknowledge that Camp Hemotion is a 7 day residential program and that attendance for the entire period is required. I understand that the only exemption to this duration of stay is by medical necessity and I will not attempt to leave prior to the end of camp for any other reason.

X _____
 Your Signature Date
(SIGNATURE IS MANDATORY)

What To Bring -- Check List

Must Have Items -- Check List

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Towels for swimming & showering | <input type="checkbox"/> 2 Pairs Pajamas | <input type="checkbox"/> Underwear/Socks for 6 days | <input type="checkbox"/> Pillows |
| <input type="checkbox"/> Sleeping Bag (or Sheets & Blankets) | <input type="checkbox"/> 3 Pairs Shorts / Cutoffs | <input type="checkbox"/> 6 Pairs Long Pants/ Sweat Pants /Jeans | <input type="checkbox"/> Comb & Brush |
| <input type="checkbox"/> Lace up tennis shoes (2 pairs recommended) | <input type="checkbox"/> Bathing Suit | <input type="checkbox"/> Warm Jacket | <input type="checkbox"/> Sun Screen |
| <input type="checkbox"/> Bug Repellent | <input type="checkbox"/> Toiletries | <input type="checkbox"/> Sweater / Sweatshirt | <input type="checkbox"/> Soap |
| <input type="checkbox"/> 6 Short Sleeved Shirts / T-Shirts | <input type="checkbox"/> Toothbrush/ Toothpaste | <input type="checkbox"/> Extra Pair of Shoes for water fight. Can be lace up or sandal with ankle strap. NO FLIP FLOPS! | |

Might Want to Have Items -- Check List

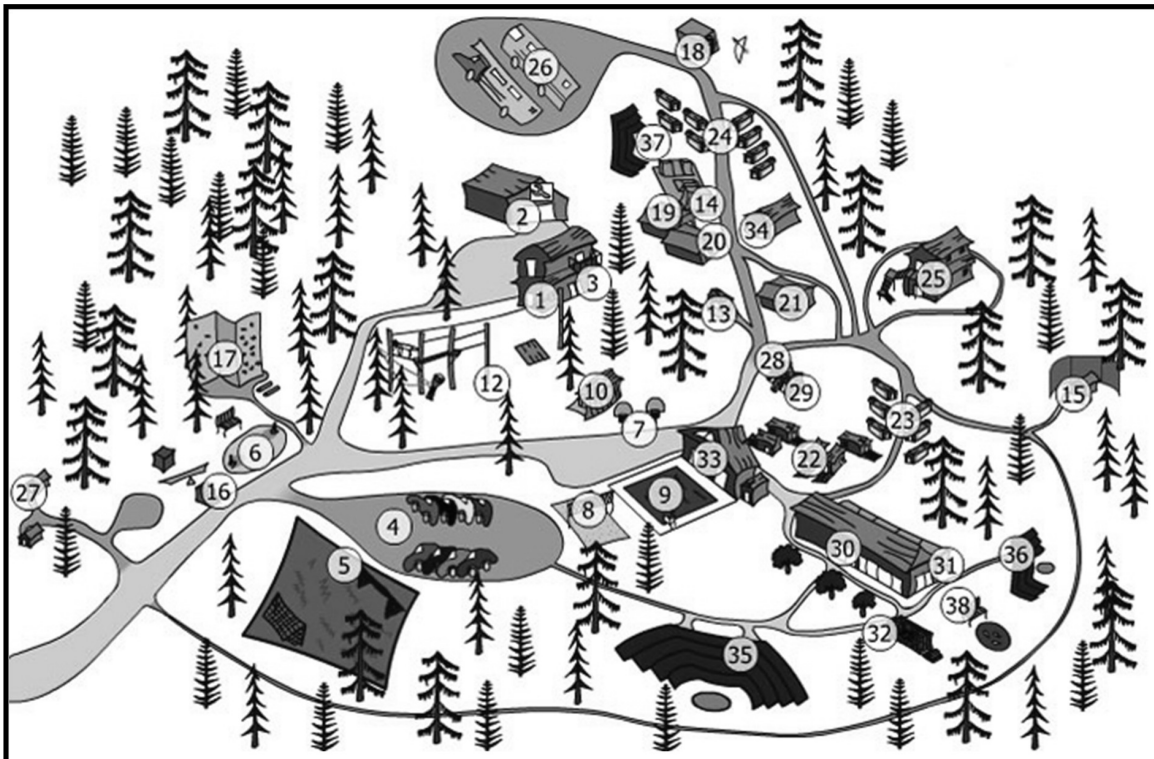
- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Musical Instruments | <input type="checkbox"/> Writing Paper, Pen, Stamps | <input type="checkbox"/> Costumes / Props | <input type="checkbox"/> Sun Hat |
| <input type="checkbox"/> Light Weight Robe | <input type="checkbox"/> Rubber Sandals for shower | <input type="checkbox"/> Flashlights & Head lamps | <input type="checkbox"/> Sports / Field Equipment |

Things To Leave At Home

- | | | | | |
|------------------|---------------|-----------------|---------------------------|--------|
| Money | Knives Pocket | Portable TV's | BoomBoxes | Radios |
| iPods/MP3 Player | B-B guns | Pets or Animals | Candy or food of any kind | |

If ANY of these items are brought to camp, they will be confiscated by the Camp Director and held until the end of camp.

Camp Oakhurst



1. Administrative Building
2. Maintenance Building
3. Friendship Conf. Room
4. Main Parking Lot
5. Ball Field
6. Horseshoe Pit
7. Basketball Court
8. Volleyball Court

9. Pool
10. Staff Lounge
11. Frisbee Golf
12. High Ropes Course
13. Bike Shed
14. Skate Park
15. Paint Ball Course
16. Low Ropes Course

DIRECTORY

17. Climbing Wall
18. Archery
19. Wright Cabin
20. McCoy Cabin
21. Heinrich Cabin
22. Chalet Cabin

23. Alpine Cabins 1-6
24. Alpine Cabins 7-14
25. Cedar Lodge (Meeting Rm)
26. R.V. Sites
27. Staff Housing
28. Snack Shack
29. Gift Store
30. Dining Hall (Meeting Rm)

31. Outdoor Dining
32. BBQ Pit
33. Pool Bathhouse
34. Back Bathhouse
35. Main Amphitheater
36. Oak Glen Amph.
37. Back Amph.
38. Koi Pond

CAMP OAKHURST MEDICAL AND LIABILITY RELEASE FORM
Hemophilia Foundation
of Northern California



Name of Church or Group _____ Dates attending _____

Last Name _____ First _____
(Camper / Leader / Speaker / Volunteer, etc.)

Address _____ City _____ ST ____ Zip _____

In Emergency, notify: _____ Relationship _____
(Parent or Guardian's name if under 18)

Home Phone _____ Work _____ Cell _____

e-mail address: _____

Birthdate _____ Age _____ Gender _____ Allergies _____

Date of last Tetanus Shot _____ Food Restrictions _____

Activity Restrictions _____

Physician _____ Phone Number _____

MEDICAL RELEASE: This health history is correct so far as I know and this person has permission of the undersigned to engage in all camp activities except as noted. In case of illness or injury, Camp Oakhurst has my permission to procure medical treatment for the above named (minor, if applicable). I understand Camp Oakhurst does not provide medical insurance or reimbursement for medical fees or prescriptions and that I am responsible for any / all such fees and charges arising from illness or injury that may occur.

LIABILITY RELEASE: The undersigned, for himself or herself and on behalf of his or her child(ren) or ward(s) and their personal representatives assigns or heirs, (hereinafter referred to as Releasors,) hereby releases and agrees and covenants not to sue Camp Oakhurst, their owners, directors, stock holders, agents, successors, or any employee, (herein after referred to as Releasees,) from any and all liability for loss, damage, injury, death, or any other claim whatever to the person or property of any guest or participant whether caused by negligence of Releasees or any other person or thing while participating in activities sponsored by or associated with Camp Oakhurst. The undersigned elects to participate and / or allow his or her child(ren), ward(s), to participate voluntarily and assumes all risk of loss, damage, injury or death, known or unknown, foreseen or unforeseen, that may be sustained.

YOU HAVE THE OPTION NOT TO PARTICIPATE OR ALLOW YOUR CHILD, CHILDREN, WARD OR WARDS NOT TO PARTICIPATE IN ANY ACTIVITY WHERE YOU DO NOT WISH TO WAIVE LIABILITY. IT SHALL BE YOUR RESPONSIBILITY TO INSURE THAT YOUR CHILD, CHILDREN, WARD OR WARDS DO(ES) NOT PARTICIPATE IN THE ACTIVITIES FOR WHICH YOU CHOOSE NOT TO BEAR LIABILITY.

The undersigned has read and voluntarily signs this medical release and waiver of all liability.

Signature _____ Date _____

IMAGE AND INFORMATION USE PERMISSION

I give permission to Camp Oakhurst to use images (still photography or video footage) of the above mentioned person for future promotional materials, including but not limited to, brochures and web site postings, without expectation of compensation. I also give permission to Camp Oakhurst to use my mailing and e-mail addresses for Camp Oakhurst mailings and information only.

Yes No _____ Signature (Parent or Guardian if under 18) _____ Date

CAMP HEMOTION 2010
ASSISTANT COUNSELOR
APPLICATION

DISCLOSURE AND AUTHORIZATION FORM

The Hemophilia Foundation of Northern California (HFNC) is requesting your authorization to obtain a consumer report and/or investigative consumer report on you in connection with your application for Camp Hemotion. Intelius Inc., a consumer reporting agency, will obtain the report for HFNC. Intelius is located at 500 108th Avenue NE, 25th Floor, Bellevue, WA 98004, and can be reached at (425) 974-6100.

The report may contain information bearing on your character, general reputation, personal characteristics. The types of information that may be obtained include, but are not limited to: *social security number verification, credit reports, criminal records checks, public court records checks, driving records checks*. The information contained in the report will be obtained from private and/or public record sources including sources identified by you in your job application or through interviews or correspondence with your past or present coworkers, neighbors, friends, associates, current or former employers, educational institutions or other acquaintances. Provided to you with this authorization is a summary of your rights under the Fair Credit Reporting Act in a form prescribed by the Federal Trade Commission. Please do not sign the authorization until you have reviewed this summary.

You also are entitled to request more information about the nature and scope of the report we are requesting your authorization to obtain by submitting a written request to Hemophilia Foundation of Northern California.

CAMP HEMOTION 2011
ASSISTANT COUNSELOR
APPLICATION

AUTHORIZATION

I have carefully read and understand this notice and authorization form and I have read and understand the "Summary of Your Rights Under the Fair Credit Reporting Act" provided with this form. By my signature below, I consent to the release of consumer and/or investigative consumer reports to HFNC as described above and consistent with the requirements imposed on HFNC as described in the Summary. I understand that, to the extent allowed by law, information contained in my job application or otherwise disclosed to HFNC by me before, during or after my employment, if any, may be utilized for the purpose of obtaining such consumer reports and/or investigative consumer reports about me. I understand that if HFNC hires me, it may request a consumer report and/or an investigative consumer report about me, to the extent allowed by law, for employment related purposes during and after my employment. I understand that if employed by HFNC my consent will apply throughout the entire time I am employed by HFNC unless I revoke or cancel my consent by sending a signed letter to **Hemophilia Foundation of Northern California**.

Employee Last Name _____ First _____ Middle _____
Present Address _____

City/State/Zip _____

Social Security Number _____

Driver's License Number _____ State _____

Professional License Number: _____ State _____ Type _____

By checking this box, I request a free copy of the report.

FOR IDENTIFICATION PURPOSES ONLY

Date of Birth _____ Gender _____

I, _____, understand that by signing below, I give authorization for the Hemophilia Foundation of Northern California to procure a consumer report and/or investigative consumer report on me in connection with my application for Camp Hemotion. I also understand that I can receive a free copy of this report if I desire by sending a signed request to the Hemophilia Foundation of Northern California. The Hemophilia Foundation of Northern California will not disclose any information contained in the reports to any other third party or outside source and the information will remain confidential.

Signature _____ Date _____

**SUMMARY OF YOUR RIGHTS
UNDER THE FAIR CREDIT REPORTING ACT**

The federal Fair Credit Reporting Act (FCRA) is designed to promote accuracy, fairness, and privacy of information in the files of every "consumer reporting agency" (CRA). Most CRAs are credit bureaus that gather and sell information about you -such as if you pay your bills on time or have filed bankruptcy -to creditors, employers, landlords, and other businesses. You can find the complete of the FCRA, 15 §§ 1681-1681u, at the Federal Trade Commission's web site (<http://www.ftc.gov>). The FCRA gives you specific rights, as outlined You may have additional rights under state law. You may contact a state or local consumer protection agency or a state attorney general to learn those rights.

- You must be told if information in your file has been used against you. Anyone who uses information from a CRA to take action against you -such as denying an application for credit, insurance, or employment -must tell you, and give you the name, address, and phone number of the CRA that provided the consumer report.
- You can find out what is in your file. At your request, a CRA must give you the information in your file, and a list of everyone who has requested it recently. There is no charge for the report if a person has taken action against you because of information supplied by the CRA, if you request the report within 60 days of receiving notice of the action. You also are entitled to one free report every twelve months upon request if you certify that (1) you are unemployed and plan to seek employment within 60 days, (2) you are on welfare, or (3) your report is inaccurate due to fraud. Otherwise, a CRA may charge you up to eight dollars.
- You can dispute inaccurate information with the eRA. If you tell a CRA that your file contains inaccurate information, the CRA must investigate the items (usually within 30 days) by presenting to its information source all relevant evidence you submit, unless your dispute is frivolous. The source must review your evidence and report its findings to the CRA. (The source also must advise national CRAs -to which it has provided the data -of any error.) The CRA must give you a written report of the investigation and a copy of your report if the investigation results in any change. If the CRA's investigation does not resolve the dispute, you may add a brief statement to your file. The CRA must normally include a summary of your statement in future reports. If an item is deleted or a dispute statement is filed, you may ask that anyone who has recently received your report be notified of the change.
- Inaccurate information must be corrected or deleted. A CRA must remove or correct inaccurate or unverified information from its files, usually within 30 days after you dispute it. However, the CRA is not required to remove accurate data from your file unless it is outdated (as described below) or cannot be verified. If your dispute results in any change to your report, the CRA cannot reinsert into your file a disputed item unless the information source verifies its accuracy and completeness. In addition, the must give you a written notice telling you it has reinserted the item The notice must include the name, address and phone number of the information source.
- You can dispute inaccurate items with the source of the information, If you tell anyone such as a creditor who reports to a CRA -that you dispute an item, they may not then report the information to a CRA without including a notice of your dispute, In addition, once you've notified the source of the error in it may not continue to report the information if it is, in fact, an error.
- Outdated information may not be In most cases, a CRA may not report negative information that is more than seven years old; ten years for bankruptcies.
- Access to your file is limited. A CRA may provide information about you only to people with a need recognized by the FCRA -usually to consider an application with a creditor, insurer, employer, landlord, or other business.

6400 Hollis Street, Suite 6
Emeryville, CA 94608
(510) 658-3324 Phone

- Your consent is required for reports that are provided to employers, or reports that contain medical information, A CRA may not give out information about you to your employer, or prospective employer, without your A CRA may not report medical information about you to creditors, insurers, or employers without your permission.
- You may choose to exclude your name from CRA lists for unsolicited credit and insurance offers, Creditors and insurers may use file information as the basis for sending you unsolicited offers of credit or insurance, Such offers must include a toll free phone number for you to call if you want your name and address removed from future lists, If you call, you must be kept off the lists for two years, If you request, complete, and return the CRA form provided for this purpose, you must be taken off the lists indefinitely.
- You may seek damages from violators, If a CRA, a user or (in some a provider of CRA data, violates the FCRA, you may sue them in state or federal court.

The FCRA gives several different federal agencies authority to enforce the FCRA:

FOR QUESTIONS OR CONCERNS REGARDING:	PLEASE CONTACT:
CRAs, creditors and others not listed below	Federal Trade Commission Consumer Response Center - FCRA Washington, DC 20580 * 202-326-3761
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 * 800-613-6743
Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)	Federal Reserve Board Division of Consumer & Community Affairs Washington, DC 20551 * 202-452-3693
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)	Office of Thrift Supervision Consumer Programs Washington, DC 20552 * 800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 * 703-518-6360
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Division of Compliance & Consumer Affairs Washington, DC 20429 * 800-934-FDIC
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation Office of Financial Management Washington, DC 20590 * 202-366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture Office of Deputy Administrator - GIPSA Washington, DC 20250 * 202-720-7051

REQUEST FOR LIVE SCAN SERVICE
Applicant Submission



ORI: Z0001 Type of Application: Volunteer / Non-profit
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: Assistant Counselor

Agency Address Set Contributing Agency:
Northern CA Hemophilia Foundation 02844
Agency authorized to receive criminal history information Mail Code (five digit code assigned by DOJ)
6400 Hollis Street, Suite 6
Street No. Street or P.O. Box
Emeryville, CA 94608 (510) 658-3324
City State Zip Code Contact Name (Mandatory for all school submissions)
Contact Telephone No.

Name of Applicant: _____
(please print) Last First MI
Alias: _____ Driver's License No. _____
Last First
Date of Birth: _____ Sex: Male Female Misc. No. BIL - 141739
Agency Billing Number
Height: _____ Weight: _____ Misc. No: _____
Eye Color: _____ Hair Color: _____ Home Address: _____
Street or P.O. Box
Place of Birth: _____ City, State and Zip Code
SOC: _____

Your Number: _____ Level of Service DOJ FBI
OCA No. (Agency Identifying No.)

If resubmission, list Original ATI No. _____

Employer: (Additional response for agencies specified by statute)

Employer Name _____
Street No. Street or P.O. Box Mail Code (five digit code assigned by DOJ)
City State Zip Code () Agency Telephone No. (optional)

Live Scan Transaction Completed By: _____ Date: _____
Name of Operator

Transmitting Agency _____ ATI No. _____ Amount Collected/Billed

APPLICANT COPY

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: Z0001 Type of Application: Volunteer / Non-profit
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: Assistant Counselor

Agency Address Set Contributing Agency:
Northern CA Hemophilia Foundation 02844
Agency authorized to receive criminal history information Mail Code (five digit code assigned by DOJ)
6400 Hollis Street, Suite 6
Street No. Street or P.O. Box Contact Name (Mandatory for all school submissions)
Emeryville, CA 94608 (510) 658-3324
City State Zip Code Contact Telephone No.

Name of Applicant: _____
(please print) Last First MI
Alias: _____ Driver's License No. _____
Last First
Date of Birth: _____ Sex: Male Female Misc. No. BIL - 141739
Agency Billing Number
Height: _____ Weight: _____ Misc. No: _____
Eye Color: _____ Hair Color: _____ Home Address: _____
Street or P.O. Box
Place of Birth: _____ City, State and Zip Code
SOC: _____

Your Number: _____ Level of Service DOJ FBI
OCA No. (Agency Identifying No.)
If resubmission, list Original ATI No. _____

Employer: (Additional response for agencies specified by statute)
Employer Name _____
Street No. Street or P.O. Box Mail Code (five digit code assigned by DOJ)
City State Zip Code () Agency Telephone No. (optional)

Live Scan Transaction Completed By: _____ Date: _____
Name of Operator
Transmitting Agency ATI No. Amount Collected/Billed

LIVE SCAN OPERATOR COPY