

## Fingerprint Consent Form Medical Cannabis Registry Identification Card

Pursuant to the Compassionate Use of Medical Cannabis Pilot Program Act, applicants for a Medical Cannabis Registry Identification Card must have a fingerprint-based criminal history record information background check. The Illinois Department of Public Health will comply with rules and regulations concerning your criminal background check authorized by the Compassionate Use of Medical Cannabis Pilot Program Act (410 ILCS 130), the UCIA (20 ILCS 2635) and applicable federal statute. This form captures the information required by licensed live scan fingerprint vendors to ensure your fingerprints are submitted properly. A transaction control number (TCN) will be issued by the live scan fingerprint vendor at the time of transmission of fingerprints. The TCN is verification your prints were taken and the vendor must fill in the TCN on this consent form. The live scan vendor will use the applicant information to help confirm your identification documentation before the fingerprints are taken. This document also serves as your consent form. The form must be signed in order to authorize the release of any criminal history record information that may exist. The results of the criminal history background check will be forwarded to the Illinois Department of Public Health for review.

### Facility Information

Requesting Agency ORI Identifier:  IL920709Z	Purpose Codes: <input type="checkbox"/> MMP Medical Marijuana Patient <input type="checkbox"/> MMC Medical Marijuana Caregiver
Requesting Agency Name and Address: Illinois Department of Public Health, 535 West Jefferson Street, Springfield, Illinois, 62761-0001	
Contact Person Name: Division of Medical Cannabis	Contact E-mail and Phone #: DPH.MedicalCannabis@illinois.gov 217-782-3300
Facility Cost Center: (If any) <i>Note: Cost is the responsibility of the applicant</i>	<b>Transaction Control Number (TCN)</b>

### Applicant Information

Name:	Sex:	Race:	Date of Birth:
SSN (optional):	Drivers License #:		DL State:

### Livescan Vendor/Appointment Information

Live Scan Fingerprint Vendor Name:	Address:		
Phone Number:	Appointment Date:	Appointment Time:	

### Privacy Statement

I, the undersigned, 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 where permitted by law. 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 Consent

Applicant Name (printed):	Date:
Applicant Name (signature):	Date: