



DATE			
TIME IN		TIME OUT	

Digital Fingerprinting Application Form

Surname (last Name)		Given Name 1 (first Name)	
Given Name 2 (middle Name)		Given Name 3	
Maiden Name / Another surname Used		Other Given Names Used	
Date of Birth (YYYY-MM-DD)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Language Preference <input type="checkbox"/> English <input type="checkbox"/> French	
Residential Address	City	Province	Postal Code
Telephone No.	Email		
Purpose of Fingerprinting (please select one) <input type="checkbox"/> Adoption <input type="checkbox"/> Canadian Citizenship <input type="checkbox"/> Employment (Federal Government) <input type="checkbox"/> Employment (Police) <input type="checkbox"/> Employment (Private Industry) <input type="checkbox"/> Employment (Provincial Government) <input type="checkbox"/> Employment (Other) Specify: _____			
		<input type="checkbox"/> Immigration to Canada <input type="checkbox"/> Name Change <input type="checkbox"/> National Sex Offender Registry <input type="checkbox"/> Privacy Act Request (CMP-PPU-030) <input type="checkbox"/> Record Suspension (Pardon) <input type="checkbox"/> Visa/Waiver/Border Crossing/Foreign Travel/ Work <input type="checkbox"/> Volunteer Employment <input type="checkbox"/> Other: _____	
Occupation	Employer	Reference No. / UCI/ Application No.	
Where Do you Want RCMP to send your result? (Name and Address with Postal Code) Name: Address: I, understand that giving this consent allows the results to be send to third party indicated above. Signature: _____			
(If the applicant I below 18 years old, this form must be signed by the parent or legal guardian)			
I certify that the information set out by me in this application is true and correct. I agree that I will review all the information entered in the system to make sure everything is correct and accurate, and I understand that in the event of an error due to incorrect information entered into the system, a new application with full service fee would be required. Signature: _____ Date: (YYYY-MM-DD)			
How did you hear about us? <input type="checkbox"/> Google <input type="checkbox"/> Facebook <input type="checkbox"/> Newspaper <input type="checkbox"/> lawyer/Consultant <input type="checkbox"/> Family/Friend <input type="checkbox"/> Employer <input type="checkbox"/> RCMP <input type="checkbox"/> Other: _____			