PUBLIC HEALTH DIVISION
Oregon Medical Marijuana Program

Criminal Background Check Request Form

(*Use mailing address noted below—do not send to OMMP*)

Name *(Last, first, middle)*			*Date of birth (mm/dd/yy)*	Gender ☐ Male ☐ Female
All other names used *(Last, first, middle; include maiden name)*			Social Security number *(SSN)**	
Home mailing address *(Street/apartment number)*			Driver license, military or state ID number:	
City	State	ZIP	Home/message/phone	
Home street address *(if different than mailing address)*			Cell phone	
City	State	ZIP	Email address	
Business name		Business city		MMD/MMPS number

*Providing your SSN is voluntary. The Oregon Health Authority (OHA) requests the Social Security number solely to identify the person during a criminal records check.

Have you ever been charged, arrested and/or convicted of a controlled substance-related crime?

☐ Yes ☐ No

If yes, list all charges, arrests and/or convictions involving controlled substances and the outcome regardless of how long ago. Please include the type of controlled substances involved.

Attach additional pages if needed.

	Date *(or estimate)*	List each charge, arrest or conviction	Controlled substances	County	State	Outcome
1.						
2.						
3.						

During the last five years, have you been outside of Oregon for 60 days or more in a row?

☐ Yes ☐ No

If yes, complete the following for each residence in the past five years.

Attach additional pages if needed.

	Date *(mm/dd/yy)*		City	State	Country	Name(s) used at this residence
	Start	End				
1.						
2.						
3.						

By signing below, I hereby certify that I am the person listed and that the information on this form is complete and correct. I understand that I will need to have a national criminal records check including fingerprints. My signature authorizes the OMMP program, in partnership with the Department of Human Services/Oregon Health Authority Background Check Unit, to request and receive any juvenile, police, court or investigation reports needed to complete this background check. If information is found that disqualifies me, I will receive information about how to challenge the background check information. I understand that if I provide false or incomplete information, my application may be returned as incomplete or denied. I understand that the background check may be repeated during the time the dispensary or processing site is registered.

Signature: _____ Date: _____

When fingerprints are electronically transmitted without a fingerprint card, please attach a completed copy of the "Request for Transmission of Electronic Regulatory Fingerprints" form, and note the following information:

Name of transmitting agency: _____

Date printed: _____

If you have fingerprint-related questions, please call the Background Check Unit at 503-378-5470 (option 6); toll free at 1-888-272-5545 (option 6); or by email at bcu.info@state.or.us.

Mail this completed form and fingerprint card (unless electronically transmitted) to:

DHS/OHA Background Check Unit
PO Box 14870
Salem OR 97309-5066