

**Thank you for your interest in being a Volunteer
Now, let's start the Clearance process...**

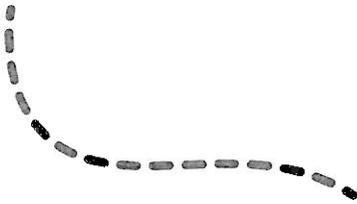


DOJ & FBI Clearance (fingerprints)

Go get your Clearance NOW!
Print this Live Scan form

No appointment necessary. Payment Required

You will need to return this form to the School Office Manager



TB Clearance

**Please have a healthcare provider complete the TB
risk assessment for you or provide a TB clearance
completed within the last 60 days**



**Please remember:
You must get your
fingerprinting & TB done
before you can begin
volunteering.**



**Please refer back to the School Office Manager
for status of clearance**



REQUEST FOR LIVE SCAN SERVICE (Public Schools or Joint Powers Agencies)

Applicant Submission

ORI: A4448 Type of Applicant: Classified School Employee Credentialed School Employee
Code assigned by DOJ

The following selections are for Public Schools only:

License, Certification, Permit Peace Officer Law Enforcement Officer Volunteer

Type of License/Certification/Permit OR Working Title: La Mesa Dale Elementary Volunteer
(Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

LA MESA SPRING VALLEY SCHOOL DISTRICT
Agency Authorized to Receive Criminal Record Information
4750 DATE AVE
Street Address or P.O. Box
LA MESA CA 91942
City State ZIP Code

01771
Mail Code (five-digit code assigned by DOJ)
Vicky Giblin
Contact Name (mandatory for all school submissions)
(619) 668-5700 x6362
Contact Telephone Number

Applicant Information:

Last Name _____ First Name _____ Middle Initial _____ Suffix _____
Other Name: (AKA or Alias) _____
Last _____ First _____ Suffix _____
Date of Birth _____ Sex Male Female Driver's License Number _____
Height _____ Weight _____ Eye Color _____ Hair Color _____ Billing Number SELF- PAY
Place of Birth (State or Country) _____ Social Security Number _____ Misc. Number _____
Home Address _____ City _____ State _____ ZIP Code _____
(Agency Billing Number)
(Other Identification Number)

I have received and read the included Privacy Notice, Privacy Act Statement, and Applicant's Privacy Rights.

Applicant Signature

Date

Your Number: _____
(OCA Number (Agency Identifying Number))

Level of Service: DOJ FBI

If re-submission, list original ATI number:
(Must provide proof of rejection) _____
Original ATI Number

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

LSID

ATI Number

Amount Collected/Billed



California School Employee Tuberculosis (TB)



Risk Assessment Questionnaire

(for pre-K, K-12 schools and community college employees, volunteers and contractors)

- Use of this questionnaire is required by California Education Code sections 49406 and 87408.6, and Health and Safety Code sections 1597.055 and 121525-121555.[^]
- The purpose of this tool is to identify **adults** with infectious tuberculosis (TB) to prevent them from spreading disease.
- **Do not repeat testing** unless there are **new** risk factors since the last negative test.
- **Do not treat for latent TB infection (LTBI) until active TB disease has been excluded:**
For individuals with signs or symptoms of TB disease or abnormal chest x-ray consistent with TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

Name of Person Assessed for TB Risk Factors: _____

Assessment Date: _____

Date of Birth: _____

History of Tuberculosis Disease or Infection (Check appropriate box below)	
<input type="checkbox"/>	Yes * If there is a <u>documented</u> history of positive TB test or TB disease, then a symptom review and chest x-ray (if none performed in the previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. If the x-ray does not have evidence of TB, the person is no longer required to submit to a TB risk assessment or repeat chest x-rays.
<input type="checkbox"/>	No (Assess for Risk Factors for Tuberculosis using box below)

TB testing is recommended if <u>any</u> of the 3 boxes below are checked	
<input type="checkbox"/>	One or more sign(s) or symptom(s) of TB disease • TB symptoms include prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue.
<input type="checkbox"/>	Birth, travel, or residence in a country with an elevated TB rate for at least 1 month • Includes countries <u>other than</u> the United States, Canada, Australia, New Zealand, or Western and North European countries. • Interferon gamma release assay (IGRA) is preferred over tuberculin skin test (TST) for non-US-born persons.
<input type="checkbox"/>	Close contact to someone with infectious TB disease during lifetime
Treat for LTBI if TB test result is positive and active TB disease is ruled out	

[^]The law requires that a health care provider administer this questionnaire. A health care provider, as defined for this purpose, is any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services. A Certificate of Completion should be completed after screening is completed (page 3).

OVER →



Certificate of Completion Tuberculosis Risk Assessment and/or Examination

To satisfy job-related requirements in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055, 121525, 121545 and 121555.

First and Last Name of the person assessed and/or examined:

Date of assessment and/or examination: _____ mo./_____ day/_____ yr.

Date of Birth: _____ mo./_____ day/_____ yr.

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

X _____

Signature of Health Care Provider completing the risk assessment and/or examination

Please print, place label or stamp with Health Care Provider Name and Address (include Number, Street, City, State, and Zip Code):

This MUST be filled out →