FINGERPRINT REQUEST FORM

Bring with you two (2) original IDs (Identity Source Documents) from the list below
https://www.oit.va.gov/programs/piv/_media/docs/IDMatrix.pdf
Complete all fields on this form to the best of your ability

Applicant Category: Check One

☐	**EMPLOYEE**	☐	**CONTRACTOR**	☐	**HEALTH PROFESSONS TRAINEE (VHA intern, resident, fellow, student)**
☐	**AFFILIATE**	☐	**VOLUNTEER**	☐	**OTHER:**

ENTER YOUR NAME EXACTLY AS IT APPEARS ON IDs

Name: (Last, First, Middle)		Other Last Names Used
SSN (use of pseudo number is not permitted)	Position Title HEALTH PROFESSION TRAINEE	Telephone #
Date of Birth: (mm/dd/yyyy)	City/State and Country of Birth	
E-Mail Address	Country of Citizenship	Dual Citizen? No
VA Work Location COLUMBIA VA HEALTH CARE SYSTEM	Organization (VHA, VBA, NCA, VACO, etc. VHA	Start Date
Contractors Only: Company Name	Company Address/Work Email	
Health Professions Trainees Only: School Name	Training Program	

FINGERPRINT LOCATION		FINGERPRINT DATE (mm/dd/yyyy)		PREVIOUS VA PIV CARD HOLDER (Yes/No)	
GENDER (M/F)	HEIGHT (inches)	WEIGHT (US pounds)	HAIR COLOR	EYE COLOR	RACE/ETHNICITY

Courtesy Prints for another Facility: ☐
Facility: Columbia SC VA Health Care System
SOI# VAJ7

SON# 1721

Fingerprint Results Cleared: YES NO (Circle One)
Date/Initials of Clearance: _____