FINGERPRINT RETENTION FEE PAYMENT

I, _____, hereby remit a $6 payment in the form of a check or money
Name of Caregiver

order for the annual participation fee of the Applicant Fingerprint Retention and Notification Program (AFRNP). The following information is submitted to substantiate the payment.

Caregiver ID: _____

Date of Birth: _____

_____
Caregiver Signature Date

****

(FOR AGENCY USE ONLY)

Note: Description = Caregiver ID + 2-Digit Month + 2-Digit Year of Retention Anniversary Date

									FLAIR ACCOUNT CODE																					
6	4	2	0	2	3	3	9	0	6	0	6	4	2	0	0	5	0	0	0	0	0	0	0	1	0	0	0	0
ORGANIZATION CODE																	**DESCRIPTION**											
6	4	6	0	0	7	0	0	0	0	0																		

CERTIFIED TRUE AND CORRECT this ____ day of _____, _____.

_____
Agency

_____
Signature of Authorized Person

_____
Title

OMMU Contact Information:
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MMUR_Applications@flhealth.gov