SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

Form approved: OMB No. 3206 0258

INSTRUCTIONS

This form is supplemental to SF 85P, Questionnaire for Public Trust Positions, but is used only after an offer of employment has been made and when the information it requests is job-related and justified by business necessity. Other than this restriction to its use, this form has the same purposes and authorities described on SF 85P. The agency which gave you this form will tell you which questions to answer.

Instructions for completing this form are the same as SF 85P.

PUBLIC BURDEN INFORMATION: Public burden reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Reports and Forms Management Officer, U.S. Office of Personnel Management, 1900 E Street, N.W., Room CHP-500, Washington DC 20415. Do not send your completed form to this address.

Section 1 - Full Name (Enter your full name exactly as it appears on your SF 85P, Questionnaire for Public Trust Positions.)									
Last name		First name	Middle name		Suffix				
DENTIFICATION INFOR	RMATION								
Section 2 - Social Se	curity Number								
Social Security Numbe	r								
SUPPLEMENTAL QUES	STIONS								
Section 3 - Your Use	of Illegal Drugs and Drug Ac	tivity							
as evidence against by the Federal gove	t you in a subsequent criminal pernment. The following question	your truthful responses nor information derived from roceeding. As to this particular section, this applies w s pertain to the illegal use of drugs or controlled subst hough permissible under state laws.	hether or not you a	re currently e	mployed				
marijuana, cod	caine, crack cocaine, hashish, n	chever is shorter, have you illegally used any controlle arcotics (opium, morphine, codeine, heroin, etc.), am c.), hallucinogenics (LSD, PCP, etc.), or prescription d	phetamines, depres		ES NO				
		stance while employed as a law enforcement officer, p ; or while in a position directly and immediately affecti			res Ono				
If you answere of times each w		provide the date(s), identify the controlled substance(s) and/or prescription	on drugs used	d, and the number				
Month/Year	Month/Year	Controlled Substance/Prescription Drug Used	Number of Times	Used	_				
	То								
	То								
Section 4 - Your Use	of Alcohol								
	has your use of alcoholic beve as for alcohol abuse or alcoholis	rages (such as liquor, beer, wine) resulted in any alcom)?	hol-related treatme	nt or \(\rightarrow \text{Y}	ES NO				
If you answered "Y	es", provide the dates of treatn	nent and the name and address of the counselor belo	W.						
Month/Year	Month/Year	Name/Address of the Counselor or Doctor		State	Zip Code				
	То								
	То								

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

Form approved: OMB No. 3206 0258

Section 5 - Psychological and Emotional Health

The U.S. government recognizes the critical importance of mental health and advocates proactive management of mental health conditions to support the wellness and recovery of Federal employees and others. Every day individuals with mental health conditions carry out their duties without presenting a security risk. While most individuals with mental health conditions do not present security risks, there may be times when such a condition can affect a person's eligibility for a security clearance.

Individuals experience a range of reactions to traumatic events. For example, the death of a loved one, divorce, major injury, service in a military combat environment, sexual assault, domestic violence, or other difficult work-related, family, personal, or medical issues may lead to grief, depression, or other responses. The government recognizes that mental health counseling and treatment may provide important support for those who have experienced such events, as well as for those with other mental health conditions. Nothing in this questionnaire is intended to discourage those who might benefit from such treatment from seeking it.

Mental health treatment and counseling, in and of itself, is not a reason to revoke or deny eligibility for access to classified information or for holding a

	e position, suitability or fitness to obtain o or information systems. Seeking or rece y.				
5A	Has a court or administrative agency E	VER issued an order declaring you m	nentally incomp	petent? YES	NO (If NO, proceed to Section 5B)
Comp	olete the following if you responded 'Yes'	to having a court or administrative a	gency EVER is	ssuing an order decla	aring you mentally incompetent.
Entry	<i>,</i> #1				
Provi	de the date this occurred. (Month/Year) Est.	Provide the name of the court or a	dministrative a	gency that declared	you mentally incompetent.
	de the address of the court or administra	ative agency. (Provide City and Country	if outside the Un	ited States; otherwise, p	provide City, State and Zip Code)
Stree	t	City	State	Zip Code	Country
	this matter appealed to a higher court or YES NO Appeal #1	administrative agency?			
_	Provide the name of the court or adminis	strative agency.	Provide the f	inal disposition.	
F	Provide the address of the court or admir	nistrative agency. (Provide City and Col	untry if outside th	e United States; otherv	vise, provide City, State and Zip Code)
;	Street	City	State	Zip Code	Country
7	Appeal #2				
_	Provide the name of the court or adminis	strative agency.	Provide the f	inal disposition.	
F	Provide the address of the court or admir	nistrative agency. (Provide City and Co	untry if outside th	e United States; otherv	vise, provide City, State and Zip Code)
;	Street	City	State	Zip Code	Country

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

Form approved: OMB No. 3206 0258

Section 5A - Psychological and Emotional Health - (Continued)

try #2				
ovide the date this occurred	(Month/Year) Provide the name	e of the court or administrativ	e agency that decl	ared you mentally incompetent.
ovide the address of the cou	urt or administrative agency. (Provid	de City and Country if outside the	United States; other	vise, provide City, State and Zip Code)
eet	City	State	Zip Code	Country
s this matter appealed to a	higher court or administrative ager	ncy?		
YES NO				
Appeal #1				
Provide the name of the o	court or administrative agency.	Provide th	e final disposition.	
		•		
Provide the address of the Street	e court or administrative agency. <i>(F</i> City	Provide City and Country if outsid State	e the United States; of Zip Code	otherwise, provide City, State and Zip Code) Country
		•		
Appeal #2		State		
Appeal #2 Provide the name of the o	City Court or administrative agency.	State Provide the	Zip Code	• • • • • • • • • • • • • • • • • • • •

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

Form approved: OMB No. 3206 0258

Section 5A - Psychological and Emotional Health - (Continued)

emplete the following if you re	esponded 'Yes' to having a court or adr	ministrative agency EVER	l issuing an order	declaring you mentally incompetent.
ntry #3				
ovide the date this occurred	. (Month/Year) Provide the name of t	he court or administrative	agency that decl	ared you mentally incompetent.
	urt or administrative agency. (Provide Cit			
reet	City	State 	Zip Code 	Country
as this matter appealed to a	higher court or administrative agency?			
YES NO				
Appeal #1				
Provide the name of the o	court or administrative agency.	Provide the	e final disposition.	
	e court or administrative agency. (Provide	le City and Country if outside	the United States; of	therwise, provide City, State and Zip Code)
Street	City	State	Zip Code	Country
Appeal #2	·	<u>.</u>		•
Provide the name of the o	court or administrative agency.	Provide the	e final disposition.	
Provide the address of the	e court or administrative agency. (Provide	de City and Country if outside	the United States; o	therwise, provide City, State and Zip Code)
Provide the address of the Street	e court or administrative agency. <i>(Provid</i> City	de City and Country if outside State	the United States; o	therwise, provide City, State and Zip Code) Country

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

Form approved: OMB No. 3206 0258

Section 5B - Psychological and Emotional Health - (Continued)

professional (for example, a psychiatrist (An order to a military member by a sup and therefore would not require an affirm within the scope of the question and wo	t, psychologist, licensed clinical socia erior officer is not within the scope of mative response. An order by a milita	l worker, etc.)? this question,	O TES	NO (If NO, proceed to Section 5C)
Complete the following if you answered 'Yes' t	to having a court or administrative age	ency EVER ord	dered you to consult	with a mental health professional.
Entry #1				
Provide the date this occurred. (Month/Year) Est.	Provide the name of the court or adn professional.	ninistrative age	ency that ordered you	u to consult with a mental health
Provide the address of the court or administra Street	tive agency. <i>(Provide City and Country i</i> City		-	rovide City, State and Zip Code) Country
Was this matter appealed to a higher court or YES NO Appeal #1	administrative agency?			
Provide the name of the court or adminis	trative agency	Dravida tha fi	nal disposition.	
Frovide the name of the court of adminis	uauve agency.		nai disposition.	
Provide the address of the court or admin	istrative agency. (Provide City and Cou	ntry if outside the	e United States; otherwi	ise, provide City, State and Zip Code)
Street	City	State	Zip Code	Country
Appeal #2		_		
Provide the name of the court or adminis	trative agency.	Provide the fi	nal disposition.	
Provide the address of the court or admin	istrative agency. (Provide City and Cou	ntry if outside the	e United States; otherwi	ise, provide City, State and Zip Code)
Street	City	State	Zip Code	Country

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

Form approved: OMB No. 3206 0258

Section 5B - Psychological and Emotional Health - (Continued)

Complete the following if you answered 'Yes' t	o having a court or administrative ac	encv EVER or	rdered you to consult	with a mental health professional.
Entry #2		, =		The state of the s
Provide the date this occurred. (Month/Year) Est.	Provide the name of the court or a professional.	dministrative a	agency that ordered y	ou to consult with a mental health
Provide the address of the court or administrate Street	tive agency. (Provide City and Country City	if outside the Un		provide City, State and Zip Code) Country
Provide the final disposition.		I		
Was this matter appealed to a higher court or YES NO	administrative agency?			
Appeal #1				
Provide the name of the court or administ	trative agency.	Provide the f	final disposition.	
Provide the address of the court or admin	istrative agency. (Provide City and Co	untry if outside th	ne United States; otherv	vise, provide City, State and Zip Code)
Street	City	State	Zip Code	Country
Appeal #2	-		•	
Provide the name of the court or administ	rative agency.	Provide the t	final disposition.	
Provide the address of the court or admin	istrative agency. (Provide City and Co	untry if outside th	ne United States; otherv	vise, provide City, State and Zip Code)
Street	City	State	Zip Code	Country

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

Form approved: OMB No. 3206 0258

Section 5C - Psychological and Emotional Health - (Continued)

5C Have you EVER been hospitalized for a mental health condition?	YES NO (If NO, proceed to Section 5D)
Complete the following if you answered 'Yes' to having EVER been hospitalized for a	nental health condition.
Entry #1	
Was the admission voluntary or involuntary?	Provide the dates of treatment.
☐ Voluntary Explanation ▶	From Date To Date (Month/Year) Est.
☐ Involuntary Explanation ▶	Est. Present
Provide the name of the facility where treatment was provided.	
Provide the address of the facility where treatment was provided. (Provide City and Cou Street City St	ntry if outside the United States; otherwise, provide City, State and Zip Code) ate Zip Code Country
Entry #2	
Was the admission voluntary or involuntary?	Provide the dates of treatment.
☐ Voluntary Explanation ▶	From Date To Date (Month/Year) Est.
☐ Involuntary Explanation ▶	Est. Present
Provide the name of the facility where treatment was provided.	
Provide the address of the facility where treatment was provided. (Provide City and Cou Street City St	ntry if outside the United States; otherwise, provide City, State and Zip Code) ate Zip Code Country

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

Form approved: OMB No. 3206 0258

Section 5C - Psychological and Emotional Health - (Continued)

Complete the following if you answered 'Yes'	to having EVER been hospitalized fo	or a me	ntal healt	th condition			
Entry #3							
Was the admission voluntary or involuntary?			Provide	the dates o	of treatment.		
☐ Voluntary Explanation ▶				om Date		To Date (Month/Year)	Est.
☐ Involuntary Explanation ▶					Est.		Present
Provide the name of the facility where treatme	ent was provided.						
Provide the address of the facility where treat Street	ment was provided. <i>(Provide City and</i> City	Country State		e the United S Zip Code	States; otherwis Coul		and Zip Code)
Entry #4							
Was the admission voluntary or involuntary?			Provide	the dates o	of treatment.		
Voluntary Explanation ▶				om Date		To Date (Month/Year)	Est.
☐ Involuntary Explanation ▶					Est.		Present
Provide the name of the facility where treatme	ent was provided.						
Provide the address of the facility where treat	ment was provided. (Provide City and	Country	if outside	e the United S	States; otherwis	e, provide City, State	and Zip Code)
Street	City	State		Zip Code	Cou	ntry	

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

Form approved: OMB No. 3206 0258

Section 5D - Psychological and Emotional Health - (Continued)

The following question asks whether you have been diagnosed with a specified mental health condition that may, particularly if untreated, impact your judgment, reliability, or trustworthiness. If you answer in the affirmative, we will seek additional information about the seriousness and symptoms of the condition, as well as any applicable course of treatment. It is important to note that any such diagnosis, in and of itself, is not a reason to revoke or deny eligibility for access to classified information or for holding a sensitive position, suitability or fitness to obtain or retain Federal or contract employment, or eligibility for physical or logical access to federally controlled facilities or information systems.

eligibility for physical or logical access to federal	ly controlled facilities or information sy	ystem	S.			<u>'</u>	,
5D Have you EVER been diagnosed by a physi psychiatrist, psychologist, licensed clinical s disorder, schizophrenia, schizoaffective disc borderline personality disorder, or antisocial	ocial worker, or nurse practitioner) wit order, delusional disorder, bipolar moc	h psy	chotic	○ YE	S O NO	O (If NO, proceed	d to Section 5E)
Complete the following if you answered 'Yes' t	o having EVER been diagnosed by a	physi	cian or o	other health prof	essional.		
Entry #1							
Identify the diagnosis or health condition.			Provide	the dates of dia	agnosis.		
				om Date nth/Year)	Est.	To Date (Month/Yea	Est. Present
Provide the name of the health care professio treating you for such diagnosis, or with whom	• •	′	Provide	the telephone i	number of t	he health care	professional.
			Teleph	one number	Extension	Internati number	onal or DSN phone
Provide the address of the health care profess such condition. (Provide City and Country if outsit Street	9 , .	•	e and Zip	•	nosis, or wi	•	nave discussed
Provide the name of any agency/organization/ where counseling/treatment was provided.	facility Same as ab	ove	Provide	the telephone i	number of t	he agency/org	anization/facility.
				ame as Above one number	Extension	Day Internati	☐ Night onal or DSN phone
Provide the address of agency/organization/fa (Provide City and Country if outside the United State	,		ded.		•		Same as above
Street	City	State		Zip Code	Count	ry	
Was the counseling/treatment effective in ma	l naging your symptoms?						

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

Form approved: OMB No. 3206 0258

Section 5D - Psychological and Emotional Health - (Continued)

Complete the following if you answered 'Yes' t	to having EVER been diagnosed by a	a physi	ician or o	other health prof	essional.		
Entry #2							
Identify the diagnosis or health condition.			Provide the dates of diagnosis.				
				om Date nth/Year)	Est.	To Date (Month/Year)	Est.
Provide the name of the health care profession treating you for such diagnosis, or with whom		у	Provide	the telephone r	number of the	he health care p	rofessional.
treating you for such diagnosis, or with whom	you have discussed such condition.		Teleph	one number	Extension	Day Internation number	☐ Night nal or DSN phone
Provide the address of the health care profess such condition. (Provide City and Country if outsic Street			te and Zi		Counti	-	ve discussed
Provide the name of any agency/organization/ where counseling/treatment was provided.	/facility Same as ab	oove	Provide	the telephone r	number of t	he agency/orgar	nization/facility.
				ame as above one number	Extension	Day Internation	Night
						number	iai oi Boit prioric
Provide the address of agency/organization/fa (Provide City and Country if outside the United State			ided.				Same as above
Street	City	State)	Zip Code	Countr	ry	
Was the counseling/treatment effective in ma	naging your symptoms?	1			I		
YES NO Explanation ▶							

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

Form approved: OMB No. 3206 0258

Section 5D - Psychological and Emotional Health - (Continued)

Complete the following if you answered 'Yes' to	o having EVER been diagnosed by a	phys	ician or o	other health prof	essional.		
Entry #3							
Identify the diagnosis or health condition.			Provide the dates of diagnosis.				
				om Date nth/Year)	Est.	To Date (Month/Year)	Est.
Provide the name of the health care profession treating you for such diagnosis, or with whom		У	Provide	the telephone r	number of the	he health care p	rofessional.
						Day	Night
			Teleph	one number	Extension	Internation number	al or DSN phone
Provide the address of the health care profess such condition. (Provide City and Country if outsic Street			te and Zij		Counti	-	e discussed
Provide the name of any agency/organization/ where counseling/treatment was provided.	facility Same as ab	oove	Provide	e the telephone r	number of t	he agency/orgar	ization/facility.
			S	ame as above		Day	Night
			Teleph	one number	Extension	Internation number	al or DSN phone
Provide the address of agency/organization/fa (Provide City and Country if outside the United State			ided.			s	ame as above
Street	City	State	•	Zip Code	Countr	ry	
Was the counseling/treatment effective in mar	naging your symptoms?	1		•	•		
YES ○ NO Explanation ►							

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

Form approved: OMB No. 3206 0258

Section 5D - Psychological and Emotional Health - (Continued)

Entry #4							
Identify the diagnosis or health co	ondition.			Provide the dates o			
				From Date (Month/Year)	Est.	To Date (Month/Year)	Est.
Provide the name of the health catreating you for such diagnosis, o			/	Provide the telepho	ne number of t	he health care p	rofessional.
treating you for such diagnosis, o	i with whom you have disc	ausseu suon continuon.		Telephone number	Extension	Day Internation	☐ Night
Provide the address of the health such condition. (Provide City and C Street				te and Zip Code)	diagnosis, or wi	•	ve discussed
Provide the name of any agency/where counseling/treatment was	,	Same as ab	ove	Provide the telepho	ne number of t	he agency/orgar	nization/facility.
				Same as above Telephone number		Day Internation number	☐ Night
Provide the address of agency/or (Provide City and Country if outside the				ided.	·		Same as above
Street	City		State	Zip Code	Count	гу	

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

Form approved: OMB No. 3206 0258

In the last seven years, have there been any occasions when you did not consult with a medical professional before altering or discontinuing, or failing to start a prescribed course of treatment for any of the listed diagnoses? NO (If NO, proceed to Section 5E)								
5D.1 Are you currently in treatment?				○ YES	S O NO) (If NO, proceed to Section 5E)		
Complete the following if you answered 'Yes' to currently being in treatment.								
Entry #1								
Provide the name of the health care professional providing such treatment.			Provide the telephone number of the health care professional.					
			Teleph	one number	Extension	Day Night International or DSN phone number		
Provide the address of the health care profess	sional. (Provide City and Country if outsid	e the U	nited Sta	tes; otherwise, pro	vide City, Sta	ate and Zip Code.)		
Street	City	State		Zip Code	Countr	у		
Entry #2				•				
Provide the name of the health care profession treatment.	nal providing such			the telephone r	number of the	he health care professional. Day Night International or DSN phone		
						number		
Provide the address of the health care profess	sional. (Provide City and Country if outsid	e the U	nited Sta	tes; otherwise, pro	vide City, Sta	ate and Zip Code.)		
Street	City	State		Zip Code	Countr	у		
Entry #3		1		l				
Provide the name of the health care professional providing such treatment.			Provide the telephone number of the health care professional.					
			Teleph	one number	Extension	Day Night International or DSN phone number		
Provide the address of the health care professional. (Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code.)								
Street	City	State		Zip Code	Countr	у		
Entry #4				•				
Provide the name of the health care professional providing such treatment.			Provide the telephone number of the health care professional.					
			Teleph	one number	Extension	Day Night International or DSN phone number		
Provide the address of the health care professional. (Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code.)								
Street	City	State		Zip Code	Countr	у		

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

Form approved: OMB No. 3206 0258

Section 5E - Psychological and Emotional Health - (Continued)

Complete the following if you responded 'No' to 5A, 5B, 5C, and 5D (All). If 'Yes' was selected for either 5A, 5B, 5C, or 5D, (any of them), proceed to Certification 5E Do you have a mental health or other health condition that substantially adversely affects your NO (If NO, proceed to Certification) judgment, reliability, or trustworthiness even if you are not experiencing such symptoms today? (Note: If your judgment, reliability, or trustworthiness is not substantially adversely affected by a mental health or other condition, then you should answer "no" even if you have a mental health or other condition requiring treatment. For example, if you are in need of emotional or mental health counseling as a result of service as a first responder, service in a military combat environment, having been sexually assaulted or a victim of domestic violence, or marital issues, but your judgment, reliability or trustworthiness is not substantially adversely affected, then answer "no.") Complete the following if you responded 'Yes' to having a mental health condition that adversely affects your judgment, reliability, or trustworthiness. Did you ever receive or are you currently receiving counseling or treatment for that condition? (You may choose not to answer this question. However, such consultation or treatment will not disqualify you and is considered to be a positive action.) I decline to answer (If I decline to answer, proceed to Certification) () NO Explanation ▶ Entry #1 If you responded 'Yes' to having ever received or you are currently receiving counseling or treatment for that condition. #1 Provide the dates of counseling or treatment Provide the telephone number of the health care professional. Day Night From Date (Month/Year) To Date (Month/Year) Telephone number Extension International or DSN phone Present number Provide the name of the health care professional. Provide the address of the health care professional. (Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code) Street Zip Code Country City Provide the telephone number of the agency/organization/facility. Provide the name of any agency/organization/facility Same as above Same as Above Night Day where counseling/treatment was provided. Telephone number Extension International or DSN phone number Provide the address of agency/organization/facility where counseling/treatment was provided. Same as above (Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code) Street City State Zip Code Country Provide the telephone number of the health care professional. #2 Provide the dates of counseling or treatment From Date (Month/Year) Day Night To Date (Month/Year) Est. Telephone number Extension International or DSN phone Est Present number Provide the name of the health care professional. Provide the address of the health care professional. (Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code) City Street State Zip Code Country Provide the telephone number of the agency/organization/facility. Provide the name of any agency/organization/facility Same as Above Day Night Same as above where counseling/treatment was provided. Telephone number Extension International or DSN phone number Provide the address of agency/organization/facility where counseling/treatment was provided. Same as above (Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code) Street City State Zip Code Country Have you ever chosen not to follow a prescribed course of treatment for any of these conditions? YES If YES provide explanation >

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

Form approved: OMB No. 3206 0258

Section 5E - Psychological and Emotional Health - (Continued)

Entry #2 If you responded "Yes" to having a mental health condition that adversely affects your judgment, reliability, or trustworthiness.							
## Provide the dates of counseling or treatment	Complete the following if you responded 'Y	'es' to having a mental h	nealth condition	n that adversely a	affects your judgr	nent, reliability, or trustworthiness.	
## Provide the dates of counseling or treatment	Entry #2						
Provide the dates of counseling or treatment From Date (Month/Year) To Date (Month/Year) Est. Present Present Extension International or DSN phone Provide the name of the health care professional. Provide the name of the health care professional. Provide the name of the health care professional. Provide City and Country if outside the United States: otherwise, provide City. State and Zip Code Street City State Zip Code Country		eived or you are currentl	y receiving cou	inseling or treatn	nent for that cond	lition.	
From Date (Month/Year)			, ,				
Est.	· ·		☐ Fst			<u> </u>	
Provide the address of the health care professional. (Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code) Street City State Zip Code Country Provide the name of any agency/organization/facility where counseling/treatment was provided. Provide the address of agency/organization/facility where counseling/treatment was provided. (Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code) Same as above State Zip Code Country Provide the dates of counseling or treatment Provide the dates of counseling or treatment From Date (Month/Year) To Date (Month/Year) State States; Otherwise Indicated States; Other	Est.			Telephone nur	nber Extensio	International or DSN phone	
Street	Provide the name of the health care pro	ofessional.			•		
Street	Provide the address of the health care	professional. (Provide C	ity and Country if	outside the United	States; otherwise,	provide City, State and Zip Code)	
where counseling/treatment was provided. Same as Above							
where counseling/treatment was provided. Same as Above							
Provide the address of agency/organization/facility where counseling/treatment was provided. (Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code) Street City State Provide the telephone number of the health care professional. From Date (Month/Year) Provide the name of the health care professional. Provide the address of the health care professional. Provide the address of the health care professional. Provide the name of any agency/organization/facility where counseling/treatment was provided. Provide the address of agency/organization/facility where counseling/treatment was provided. Provide the address of agency/organization/facility where counseling/treatment was provided. Provide the address of agency/organization/facility where counseling/treatment was provided. Provide the address of agency/organization/facility where counseling/treatment was provided. Provide the address of agency/organization/facility where counseling/treatment was provided. Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code) State City State Zip Code Country Same as above Provide the telephone number of the agency/organization/facility. Telephone number Extension International or DSN phone number International or DSN phone numbe		Same as above					
Street City State and Zip Code Country #2 Provide the dates of counseling or treatment From Date (Month/Year) To Date (Month/Year)				Teleph	one number	International or DSN phone	
#2 Provide the dates of counseling or treatment From Date (Month/Year) Est. Present Provide the telephone number of the health care professional.						Same as above	
From Date (Month/Year) Day Night Day	, , , , , , , , , , , , , , , , , , , ,		o ony, cialo am		Zip Code	Country	
From Date (Month/Year) Day Night Day	#2 Dravide the dates of equipoling or tree	tmant.		Dravida the tale		f the health care professional	
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SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

Form approved: OMB No. 3206 0258

CERTIFICATION

Certification That My Answers Are True

My statements on this form, and any attachments to it, are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I understand that a knowing and willful false statement on this form can be punished by fine or imprisonment or both. (See section 1001 of title 18, United States Code).

Signature (Sign in ink)	Date
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