Standard Form 85P-S
Revised December 2017
U.S. Office of Personnel Management
5 CFR Parts 731, 732, and 736

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

IDENTIFICATION INFORMATION

Section 2 - Social Security Number

Social Security Number

SUPPLEMENTAL QUESTIONS

Section 3 - Your Use of Illegal Drugs and Drug Activity

We note, with reference to this section, that neither your truthful responses nor information derived from your responses to this section will be used as evidence against you in a subsequent criminal proceeding. As to this particular section, this applies whether or not you are currently employed by the Federal government. The following questions pertain to the illegal use of drugs or controlled substances or drug or controlled substance activity not in accordance with Federal laws, even though permissible under state laws.

(a) Since the age of 16 or in the last 5 years, whichever is shorter, have you illegally used any controlled substance, for example, marijuana, cocaine, crack cocaine, hashish, narcotics (opium, morphine, codeine, heroin, etc.), amphetamines, depressants (barbiturates, methaqualone, tranquilizers, etc.), hallucinogenics (LSD, PCP, etc.), or prescription drugs? ◯YES ◯NO

(b) Have you ever illegally used a controlled substance while employed as a law enforcement officer, prosecutor, or courtroom official; while possessing a security clearance; or while in a position directly and immediately affecting the public safety? ◯YES ◯NO

If you answered "Yes" to any question above, provide the date(s), identify the controlled substance(s) and/or prescription drugs used, and the number of times each was used.

Month/Year	Month/Year	Controlled Substance/Prescription Drug Used	Number of Times Used
	To		
	To		

Section 4 - Your Use of Alcohol

In the last 5 years, has your use of alcoholic beverages (such as liquor, beer, wine) resulted in any alcohol-related treatment or counseling (such as for alcohol abuse or alcoholism)? ◯YES ◯NO

If you answered "Yes", provide the dates of treatment and the name and address of the counselor below.

Month/Year	Month/Year	Name/Address of the Counselor or Doctor	State	Zip Code
	To			
	To			

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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 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. Seeking or receiving mental health care for personal wellness and recovery may contribute favorably to decisions about your eligibility.

5A Has a court or administrative agency **EVER** issued an order declaring you mentally incompetent? ◯ YES ◯ NO *(If NO, proceed to Section 5B)*

Complete the following if you responded **'Yes'** to having a court or administrative agency **EVER** issuing an order declaring you mentally incompetent.

Entry #1

Provide the date this occurred. *(Month/Year)* ☐ Est.

Provide the name of the court or administrative agency that declared you mentally incompetent.

Provide the address of the court or administrative agency. *(Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street | City | State | Zip Code | Country

Was this matter appealed to a higher court or administrative agency?

◯ YES ◯ NO

Appeal #1

Provide the name of the court or administrative agency.

Provide the final disposition.

Provide the address of the court or administrative agency. *(Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street | City | State | Zip Code | Country

Appeal #2

Provide the name of the court or administrative agency.

Provide the final disposition.

Provide the address of the court or administrative agency. *(Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street | City | State | Zip Code | Country

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

Complete the following if you responded **'Yes'** to having a court or administrative agency **EVER** issuing an order declaring you mentally incompetent.

Entry #2

Provide the date this occurred. *(Month/Year)*

☐ Est.

Provide the name of the court or administrative agency that declared you mentally incompetent.

Provide the address of the court or administrative agency. *(Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street | City | State | Zip Code | Country

Was this matter appealed to a higher court or administrative agency?

◯ YES ◯ NO

Appeal #1

Provide the name of the court or administrative agency.

Provide the final disposition.

Provide the address of the court or administrative agency. *(Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street | City | State | Zip Code | Country

Appeal #2

Provide the name of the court or administrative agency.

Provide the final disposition.

Provide the address of the court or administrative agency. *(Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street | City | State | Zip Code | Country

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

Complete the following if you responded **'Yes'** to having a court or administrative agency **EVER** issuing an order declaring you mentally incompetent.

Entry #3

Provide the date this occurred. *(Month/Year)*

☐ Est.

Provide the name of the court or administrative agency that declared you mentally incompetent.

Provide the address of the court or administrative agency. *(Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street	City	State	Zip Code	Country

Was this matter appealed to a higher court or administrative agency?

◯ YES ◯ NO

Appeal #1

Provide the name of the court or administrative agency.

Provide the final disposition.

Provide the address of the court or administrative agency. *(Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street	City	State	Zip Code	Country

Appeal #2

Provide the name of the court or administrative agency.

Provide the final disposition.

Provide the address of the court or administrative agency. *(Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street	City	State	Zip Code	Country

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

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

5B Has a court or administrative agency **EVER** ordered you to consult with a mental health professional (for example, a psychiatrist, psychologist, licensed clinical social worker, etc.)? (An order to a military member by a superior officer is not within the scope of this question, and therefore would not require an affirmative response. An order by a military court would be within the scope of the question and would require an affirmative response.)

◯ YES ◯ NO *(If NO, proceed to Section 5C)*

Complete the following if you answered **'Yes'** to having a court or administrative agency **EVER** ordered 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 administrative agency that ordered you to consult with a mental health professional.

Provide the address of the court or administrative agency. *(Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street | City | State | Zip Code | Country

Was this matter appealed to a higher court or administrative agency?

◯ YES ◯ NO

Appeal #1

Provide the name of the court or administrative agency.

Provide the final disposition.

Provide the address of the court or administrative agency. *(Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street | City | State | Zip Code | Country

Appeal #2

Provide the name of the court or administrative agency.

Provide the final disposition.

Provide the address of the court or administrative agency. *(Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street | City | State | Zip Code | Country

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

Complete the following if you answered **'Yes'** to having a court or administrative agency **EVER** ordered you to consult with a mental health professional.

Entry #2

Provide the date this occurred. *(Month/Year)*

☐ Est.

Provide the name of the court or administrative agency that ordered you to consult with a mental health professional.

Provide the address of the court or administrative agency. *(Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street | City | State | Zip Code | Country

Provide the final disposition.

Was this matter appealed to a higher court or administrative agency?

◯ YES ◯ NO

Appeal #1

Provide the name of the court or administrative agency.

Provide the final disposition.

Provide the address of the court or administrative agency. *(Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street | City | State | Zip Code | Country

Appeal #2

Provide the name of the court or administrative agency.

Provide the final disposition.

Provide the address of the court or administrative agency. *(Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street | City | State | Zip Code | Country

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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 mental health condition.

Entry #1

Was the admission voluntary or involuntary?

☐ Voluntary Explanation ▸

☐ Involuntary Explanation ▸

Provide the dates of treatment.

From Date *(Month/Year)* ☐ Est.

To Date *(Month/Year)* ☐ 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 Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street | City | State | Zip Code | Country

Entry #2

Was the admission voluntary or involuntary?

☐ Voluntary Explanation ▸

☐ Involuntary Explanation ▸

Provide the dates of treatment.

From Date *(Month/Year)* ☐ Est.

To Date *(Month/Year)* ☐ 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 Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street | City | State | Zip Code | Country

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

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

Complete the following if you answered **'Yes'** to having **EVER** been hospitalized for a mental health condition.

Entry #3

Was the admission voluntary or involuntary?

☐ Voluntary Explanation ▸

☐ Involuntary Explanation ▸

Provide the dates of treatment.

From Date *(Month/Year)* ☐ Est.

To Date *(Month/Year)* ☐ 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 Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street | City | State | Zip Code | Country

Entry #4

Was the admission voluntary or involuntary?

☐ Voluntary Explanation ▸

☐ Involuntary Explanation ▸

Provide the dates of treatment.

From Date *(Month/Year)* ☐ Est.

To Date *(Month/Year)* ☐ 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 Country if outside the United States; otherwise, provide City, State and Zip Code)*

Street | City | State | Zip Code | Country

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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.

5D Have you **EVER** been diagnosed by a physician or other health professional (for example, a psychiatrist, psychologist, licensed clinical social worker, or nurse practitioner) with psychotic disorder, schizophrenia, schizoaffective disorder, delusional disorder, bipolar mood disorder, borderline personality disorder, or antisocial personality disorder?

◯ YES ◯ NO *(If NO, proceed to Section 5E)*

Complete the following if you answered **'Yes'** to having **EVER** been diagnosed by a physician or other health professional.

Entry #1

Identify the diagnosis or health condition.

Provide the dates of diagnosis.

From Date *(Month/Year)* ☐ Est.

To Date *(Month/Year)* ☐ Est. ☐ Present

Provide the name of the health care professional who diagnosed you, or is currently treating you for such diagnosis, or with whom you have discussed such condition.

Provide the telephone number of the health care professional.

☐ Day ☐ Night

Telephone number | Extension | ☐ International or DSN phone number

Provide the address of the health care professional who diagnosed you, or is currently treating you for such diagnosis, or with whom you have discussed such condition. *(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. ☐ Same as above

Provide the telephone number of the agency/organization/facility.

☐ Same as Above ☐ Day ☐ Night

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

Was the counseling/treatment effective in managing your symptoms?

◯ YES ◯ NO Explanation ▸

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

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

Complete the following if you answered **'Yes'** to having **EVER** been diagnosed by a physician or other health professional.

Entry #2

Identify the diagnosis or health condition.

Provide the dates of diagnosis.

From Date *(Month/Year)* ☐ Est.

To Date *(Month/Year)* ☐ Est. ☐ Present

Provide the name of the health care professional who diagnosed you, or is currently treating you for such diagnosis, or with whom you have discussed such condition.

Provide the telephone number of the health care professional.

☐ Day ☐ Night

Telephone number Extension ☐ International or DSN phone number

Provide the address of the health care professional who diagnosed you, or is currently treating you for such diagnosis, or with whom you have discussed such condition. *(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. ☐ Same as above

Provide the telephone number of the agency/organization/facility.

☐ Same as above ☐ Day ☐ Night

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

Was the counseling/treatment effective in managing your symptoms?

◯ YES ◯ NO Explanation ▸

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

Complete the following if you answered **'Yes'** to having **EVER** been diagnosed by a physician or other health professional.

Entry #3

Identify the diagnosis or health condition.

Provide the dates of diagnosis.

From Date *(Month/Year)* ☐ Est.

To Date *(Month/Year)* ☐ Est. ☐ Present

Provide the name of the health care professional who diagnosed you, or is currently treating you for such diagnosis, or with whom you have discussed such condition.

Provide the telephone number of the health care professional.

☐ Day ☐ Night

Telephone number Extension ☐ International or DSN phone number

Provide the address of the health care professional who diagnosed you, or is currently treating you for such diagnosis, or with whom you have discussed such condition. *(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. ☐ Same as above

Provide the telephone number of the agency/organization/facility.

☐ Same as above ☐ Day ☐ Night

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

Was the counseling/treatment effective in managing your symptoms?

◯ YES ◯ NO Explanation ▸

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

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

Complete the following if you answered **'Yes'** to having **EVER** been diagnosed by a physician or other health professional.

Entry #4

Identify the diagnosis or health condition.

Provide the dates of diagnosis.

From Date *(Month/Year)* ☐ Est.

To Date *(Month/Year)* ☐ Est. ☐ Present

Provide the name of the health care professional who diagnosed you, or is currently treating you for such diagnosis, or with whom you have discussed such condition.

Provide the telephone number of the health care professional.

☐ Day ☐ Night

Telephone number | Extension | ☐ International or DSN phone number

Provide the address of the health care professional who diagnosed you, or is currently treating you for such diagnosis, or with whom you have discussed such condition. *(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. ☐ Same as above

Provide the telephone number of the agency/organization/facility.

☐ Same as above ☐ Day ☐ Night

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

Was the counseling/treatment effective in managing your symptoms?

◯ YES ◯ NO Explanation ▸

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

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

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? ◯ YES ◯ NO *(If NO, proceed to Section 5E)*

5D.1 Are you currently in treatment? ◯ YES ◯ 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.

☐ Day ☐ Night

Telephone number | Extension | ☐ 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 | Country

Entry #2

Provide the name of the health care professional providing such treatment.

Provide the telephone number of the health care professional.

☐ Day ☐ Night

Telephone number | Extension | ☐ 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 | Country

Entry #3

Provide the name of the health care professional providing such treatment.

Provide the telephone number of the health care professional.

☐ Day ☐ Night

Telephone number | Extension | ☐ 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 | Country

Entry #4

Provide the name of the health care professional providing such treatment.

Provide the telephone number of the health care professional.

☐ Day ☐ Night

Telephone number | Extension | ☐ 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 | Country

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

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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 judgment, reliability, or trustworthiness even if you are not experiencing such symptoms today? ◯ YES ◯ NO *(If NO, proceed to Certification)*

(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.)

◯ YES ◯ 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

From Date *(Month/Year)* ☐ Est. To Date *(Month/Year)* ☐ Est. ☐ Present

Provide the telephone number of the health care professional.

Telephone number Extension ☐ Day ☐ Night ☐ International or DSN phone 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 City State Zip Code Country

Provide the name of any agency/organization/facility where counseling/treatment was provided. ☐ Same as above

Provide the telephone number of the agency/organization/facility.

☐ Same as Above ☐ Day ☐ Night

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

#2 Provide the dates of counseling or treatment

From Date *(Month/Year)* ☐ Est. To Date *(Month/Year)* ☐ Est. ☐ Present

Provide the telephone number of the health care professional.

Telephone number Extension ☐ Day ☐ Night ☐ International or DSN phone 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 City State Zip Code Country

Provide the name of any agency/organization/facility where counseling/treatment was provided. ☐ Same as above

Provide the telephone number of the agency/organization/facility.

☐ Same as Above ☐ Day ☐ Night

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 ▸

◯ NO

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

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

Complete the following if you responded **'Yes'** to having a mental health condition that adversely affects your judgment, reliability, or trustworthiness.

Entry #2

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

From Date *(Month/Year)* ☐ Est. To Date *(Month/Year)* ☐ Est. ☐ Present

Provide the telephone number of the health care professional.

☐ Day ☐ Night

Telephone number Extension ☐ International or DSN phone 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 City State Zip Code Country

Provide the name of any agency/organization/facility where counseling/treatment was provided. ☐ Same as above

Provide the telephone number of the agency/organization/facility.

☐ Same as Above ☐ Day ☐ Night

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

#2 Provide the dates of counseling or treatment

From Date *(Month/Year)* ☐ Est. To Date *(Month/Year)* ☐ Est. ☐ Present

Provide the telephone number of the health care professional.

☐ Day ☐ Night

Telephone number Extension ☐ International or DSN phone 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 City State Zip Code Country

Provide the name of any agency/organization/facility where counseling/treatment was provided. ☐ Same as above

Provide the telephone number of the agency/organization/facility.

☐ Same as Above ☐ Day ☐ Night

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 ▸

◯ NO

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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