Standard Form 85PS
Revised April 2006
U.S. Office of Personnel Management
5 CFR Parts 731 and 736

SUPPLEMENTAL QUESTIONNAIRE FOR SELECTED POSITIONS

Form approved:
OMB No. 3206 0005
NSN 7540-01-368-7778
86-111

Instructions

This form is supplemental to the SF 85P, Questionnaire for Public Trust Positions. This form has the same purposes, authorities, and Privacy Act Routine Uses, described on the 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 the SF 85P. Type or legibly print your answers in ink (if the form is not legible, it will not be accepted). Be sure to sign and date the certification statement at the bottom of this page.

PUBLIC BURDEN INFORMATION: Public burden reporting for this collection is 20 minutes, 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 OPM Forms Officer, U.S. Office of Personnel Management, 1900 E Street, N.W., Washington DC 20415. Do not send your completed form to this address, send it to the office that provided you the form. The OMB clearance number, 3206-0005, is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

IDENTIFICATION INFORMATION

1 FULL NAME Enter your name exactly as it appears on your SF 85P, Questionnaire for Public Trust Positions				2 SOCIAL SECURITY NUMBER
Last name	First name	Middle name	Jr.,II, etc.	

3 MENTAL AND EMOTIONAL HEALTH	YES	NO
In the last 7 years, have you received counseling or treatment from a mental health professional (including a counselor, licensed social worker, psychologist, psychiatrist, or other psychotherapist) or any other medical professional regarding an emotional or mental condition? Answer "No" if the counseling was strictly marital, family, or grief counseling and did not involve the prescription of medication or violence by you.		

If you answered "Yes," indicate who conducted the treatment, provide the following information, and sign the *Authorization for Release of Medical Information Pursuant to the Health Insurance Portability and Accountability Act (HIPAA).*

Dates of Treatment Month/Year To Month/Year	Name/Address/Zip Code of Provider	Explain circumstances of treatment
#1		
#2		

4 USE OF ALCOHOL	YES	NO
a In the last 7 years, has your use of alcohol had a negative impact on your work performance, your professional or personal relationships, or your finances, or resulted in contacts by law enforcement/public safety personnel? (If "Yes," explain.)		
b In the last 7 years, have you received counseling or treatment or have you been ordered, advised, or asked to seek counseling or treatment as a result of your use of alcohol?		

If you answered "Yes" to question **b** above, provide the dates of treatment and the name and address of the counselor or doctor below. You will be asked to sign a release if information is needed concerning your treatment. Do not repeat information reported in response to Question 3 above.

Month/Year To Month/Year	Name/Address/Zip Code of Counselor or Doctor
#1	
#2	

5 USE OF ILLEGAL DRUGS AND DRUG ACTIVITY		
The following questions pertain to the illegal use of drugs or drug activity. You are required to answer the questions fully and truthfully, and your failure to do so could be grounds for an adverse employment decision or action against you. Neither your truthful responses nor information derived from your responses will be used as evidence against you in any subsequent criminal proceeding.	YES	NO
a In the last 7 years, have you illegally used any controlled substance, for example, cocaine, crack cocaine, THC (marijuana, hashish, etc.), narcotics (opium, morphine, codeine, heroin, etc.), stimulants (amphetamines, speed, crystal methamphetamine, Ecstasy, ketamine, etc.), depressants (barbiturates, methaqualone, tranquilizers, etc.), hallucinogenics (LSD, PCP, etc.), steroids, inhalants (toluene, amyl nitrate, etc.) or prescription drugs (including painkillers)? Illegal use of a controlled substance includes injecting, snorting, inhaling, swallowing, experimenting with or otherwise consuming any controlled substance.		
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?		
c In the last 7 years, have you been involved in the illegal possession, purchase, manufacture, trafficking, production, transfer, shipping, receiving, handling, or sale of any controlled substance (see question a above) including prescription drugs?		

If you answered "Yes" to any question above (**a-c**), provide the date(s) of use or activity, identify the controlled substance(s), and explain the use or activity.

Dates of Use/Activity Month/Year To Month/Year	Type of Controlled Substance(s)	Explain nature of use/activity, frequency of activity, and number of times used
#1		
#2		

CERTIFICATION

My statements on this form, and on 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 (18 U.S.C. 1001). I understand that intentionally withholding, misrepresenting, or falsifying information will have a negative effect on my employment prospects or job status up to and including my removal and debarment from Federal service.

Signature *(Sign in ink)*	Date *(mm/dd/yyyy)*

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UNITED STATES OF AMERICA

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Carefully read this authorization to release information about you, then sign and date it in ink.

Instructions for Completing this Release

This is a release for the investigator to ask your health practitioner(s) the three questions below concerning your mental health consultations. Your signature will allow the practitioner(s) to answer only these questions.

Authorization

I am seeking assignment to or retention in a public trust position. As part of the clearance process, **I hereby authorize** the investigator, special agent, or duly accredited representative of the authorized Federal agency conducting my background investigation, to obtain the following information relating to my mental health consultations.

In accordance with HIPAA, I understand that I have the right to revoke this authorization at any time by writing to the Office of Personnel Management (OPM). I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Further, I understand that this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

I understand the information disclosed pursuant to this release is for use by the Federal Government only for purposes provided in the Standard Form 85PS and that it may be disclosed by the Government only as authorized by law, but will no longer be subject to the HIPAA privacy rule.

Copies of this authorization with my signature are valid. This authorization is valid for one (1) year from the date signed or upon termination of my affiliation with the Federal Government, whichever is sooner.

Signature *(Sign in ink)*	Full name *(Type or print legibly)*			Date signed *(mm/dd/yyyy)*
Other names used				Social Security Number
Street address Apt. #	City (Country)	State	Zip Code	Home telephone number ( )

For Use By Practitioner(s) Only

Does the person under investigation have a condition that could impair his or her judgment? ☐ **YES** ☐ **NO**
If so, describe the nature of the condition and the extent and duration of the impairment or treatment.

What is the prognosis?

Practitioner Name	Signature	Date signed (mm/dd/yyyy)