Supplemental Form Instructions

Instructions for Completing This Supplemental Form

OMB No. 3206-0005
Form: SF85PS

Read the following document before attempting to complete this form.

Supplemental Questionnaire for Selected Positions (SF85PS Format)

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 SF 85P.

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.

Continue

Section 24: Mental and Emotional Health

Section Summary

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Answer the following question.

Question	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," provide a record for each treatment to report, and sign the *Authorization for Release of Medical Information Pursuant to the Health Insurance Portability and Accountability Act (HIPAA)* (provided to you after you complete this form).

Summary of Treatments

#	Dates of Treatment	Name of Provider	Actions
1	From (~)/(~) To (~)/(~)	(~)	Edit Delete

Add an Entry

Additional Comments

Note: If you need to provide any additional comments about this information, enter them below.

Save Reset this Screen

Section 24: Mental and Emotional Health

Entry Details

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Dates of Treatment

Date	Month/Year	Est./Pres.
From:	/	
To:	/	

Indicate who conducted the treatment.

Name of Provider

Street Address

Street:			
City:			
Provide Country if outside the United States; otherwise, provide State and Zip Code.			
State:		Zip Code:	
Country: (List)			

Explain Circumstances of Treatment

Additional Comments

Note: If you need to provide any additional comments about this information, enter them below.

Save Cancel Reset this Screen

Section 25: Use of Alcohol
Section Summary

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Answer the following question.

#	Question	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, your finances, or resulted in contacts by law enforcement/public safety personnel?	☐	☐

If you answered "Yes" to question a, explain.

Explanation

Answer the following question.

#	Question	Yes	No
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 an entry for each treatment to report. You will be asked to sign a release if information is needed concerning your treatment. Do not repeat information reported in response to Section 24 (Mental and Emotional Health).

Summary of Treatments

#	Dates of Treatment	Counselor/Doctor	Actions
1	From (~)/(~) To (~)/(~)	(~)	Edit Delete
	Add an Entry		

Additional Comments

Note: If you need to provide any additional comments about this information, enter them below.

Save Reset this Screen

Section 25: Use of Alcohol
Entry Details

OMB No. 3206-0005
Form: SF85PS

Provide the dates of treatment and the name and address of the counselor or doctor.

Dates of Treatment

Date	Month/Year	Est./Pres.
From:	/	
To:	/	

Name of Counselor/Doctor

Street Address

Street:			
City:			
Provide Country if outside the United States; otherwise, provide State and Zip Code.			
State:		Zip Code:	
Country: (List)			

Additional Comments

Note: If you need to provide any additional comments about this information, enter them below.

Save Cancel Reset this Screen

Section 26: Use of Illegal Drugs and Drug Activity

Section Summary

OMB No. 3206-0005
Form: SF85PS

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.

Answer the following questions.

#	Question	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.

Summary of Substance/Drug Use/Activity

#	Dates of Use/Activity	Type of Controlled Substance(s)	Actions
1	From (~)/(~) To (~)/(~)	(~)	Edit Delete
	Add an Entry		

Additional Comments

Note: If you need to provide any additional comments about this information, enter them below.

Save Reset this Screen

Section 26: Use of Illegal Drugs and Drug Activity

OMB No. 3206-0005
Form: SF85PS

Entry Details

Dates of Use/Activity

Date	Month/Year	Est./Pres.
From:	/	
To:	/	

Type of Controlled Substance(s)

Explain Nature of Use/Activity, Frequency of Activity, and Number of Times Used

Additional Comments

Note: If you need to provide any additional comments about this information, enter them below.

Save Cancel Reset this Screen