

Program Confirmation Form

Name: Arleigh A. Burke

Cell Number: 303-123-4567 Date of Birth: 10/19/01

EMAIL ADDRESS (first.last@colorado.edu if it is set up already):

arleigh.burke@colorado.edu

Expected Major (the major you put down on your scholarship application):

Mechanical Engineering

Confirmation (check all that apply):

I will be participating in the NROTC program during the fall of 2016 at CU Boulder.

I will be participating in New Student Orientation beginning on August 8th, 2016.

My parent(s) are planning to attend the parent program brief and orientation graduation on Saturday, August 13th, 2016.

Total number of guests (not including yourself): 2

I will **NOT** be checking-in and have no plans to join NROTC at this time.

Move-In Plans (check all that apply):

My current dorm move-in date is: 08/17.

My plan after new student orientation on 13-14 August is to:

Stay at home. I live in the local area.

Stay in a hotel until my dorm move-in date. Note: You can move into the dormitory early on the 15th of August at a daily rate of \$58.50 by setting up with the on-campus housing office.)

Utilize upper-class midshipmen hosts until I can move into my dorm. (Should be used only if completely necessary)

PHYSICAL ACTIVITY RISK FACTOR QUESTIONNAIRE (PARFQ)

This document is protected under the PRIVACY ACT.

Member Name: _____

SSN: _____

Risk Assessment Date: _____

Date of your last PHA: _____

1. Are you 50 years of age or older? Yes No
2. Has anyone in your immediate family had a heart attack, died from a heart condition or died suddenly before age 50 as a result of a medical condition? Yes No
3. Has anyone in your immediate family been diagnosed with Marfan's syndrome (a body structure tissue disorder that affects the skeletal system, cardiovascular system, eyes and skin)? Yes No
4. Has your healthcare provider told you that you have a heart problem or other medical condition which limits your activities? Yes No
5. Has a healthcare provider ever counseled you on, or prescribed medication for, an increased lipid, cholesterol, or triglyceride level(s)? Yes No
6. Do you feel pain in your chest when you do physical activity? Yes No
7. In the past month, have you had chest pain when you were NOT doing physical activity? Yes No
8. Have you ever become lightheaded or dizzy, passed out, or nearly passed out during or after exercise? Yes No
9. Do you have a bone or joint problem (for example) back, knee, or hip) that could be made worse by a change in your physical activity? Yes No
10. Is your healthcare provider currently prescribing medications (for example: water pills) for a blood pressure or heart condition? Yes No
11. (Females) Are you now, or do you think you may be pregnant? Yes No
12. Are you a current smoker or have you quit smoking within the past 3 months? Yes No
13. Do you know of any reason why you should not do physical activity? Yes No

Member Signature: _____

To be completed by Medical:

PARFQ Screening completed on: _____

Results of the screening are: _____

Member is cleared to participate in the PRT. Yes No

Member incurred waiver (If yes, attach a copy of NAVMED 6110/4)? Yes No **Don't mark.**

Verified Date of Last PHA
NAVPERS 6110/3 (01/2012)

Name/Signature of MDR

PHYSICAL ACTIVITY RISK FACTOR QUESTIONNAIRE (PARFQ)

NAVPERS 6110/3 (Rev. 02-2016) PREVIOUS EDITIONS ARE OBSOLETE Supporting Directive OPNAVINST 6110.1J

PRIVACY ACT STATEMENT


AUTHORITY: 10 U.S.C. 5013. Secretary of the Navy; OPNAVINST 6110.1J, Physical Readiness Program.

PRIMARY PURPOSE: The Physical Activity Risk Factor Questionnaire (PARFQ) is a self-screening tool required of all Navy members prior to participating in the semi-annual Physical Fitness Assessment (PFA). The form assists commands and medical personnel in identifying risk factors or changes in a member's health status since the completion of the annual Physical Health Assessment (PHA).

ROUTINE USES: Disclosures are permitted under 5 U.S.C. 552a(b), Privacy Act of 1974, as amended.

DISCLOSURE: Mandatory. Failure to fully disclose the requested information may inhibit the Navy's ability to properly assess your physical activity risk factors and may subject you to administrative actions.

<p>1. Do any of the following apply to you? (<i>For Females Only</i>)</p> <ul style="list-style-type: none"> - You are pregnant, or have reason to believe you could be pregnant. - You were pregnant and/or gave birth within the past 6 months. - You miscarried or gave birth to a live or stillborn child(ren) within the past 6 months. - You are currently undergoing in vitro fertilization (IVF) treatment, or have undergone IVF within the past 6 months. <p>NOTE: If you answer "Yes" to any of the above you are NOT authorized to participate in the Physical Fitness Assessment (PFA) this cycle. Obtain pregnancy notification from your Health Care Provider (HCP). If you answer "No", proceed to question 2.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>2. Did you fully participate in the last PFA cycle? (i.e., BCA, curl-ups, push-ups, cardio)</p> <p>NOTE: If "Yes", proceed to question 4. If "No", (i.e., medical waiver for all or part of PRT), proceed to question 3.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3. For the same reason(s) you were medically waived in question 2 above, are you requesting a medical waiver for this PFA cycle? NOTE: If "Yes", STOP. Print PARFQ and schedule a medical appointment with primary HCP. If "No", (i.e., not requesting a medical waiver), proceed to question 4.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>4. Is your Periodic Health Assessment (PHA) out of date (i.e., more than one year has elapsed since your last PHA)?</p> <p>NOTE: If "Yes", STOP. Print this PARFQ. Schedule a medical appointment with primary HCP and take this PARFQ to the medical appointment. PRT is NOT authorized until you complete the PHA. If "No", proceed to question 5.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>5. Have you experienced any of the following symptoms/problems since the last PFA cycle that were NOT evaluated by a health care provider?</p> <ul style="list-style-type: none"> - Unexplained chest discomfort. - Unusual or unexplained shortness of breath. - Dizziness, fainting, or blackouts associated with exertion. - Other medical issues (including bone and joint problems) that would keep you from safely participating in the PRT. <p>NOTE: If "Yes", STOP. Print PARFQ. Schedule a medical appointment with primary HCP to obtain a medical evaluation prior to the PRT. Authorized Medical Department Representative (AMDR)/HCP will endorse PARFQ after a health determination is confirmed. If "No", proceed to question 6.</p>	<p style="color: red; font-size: small;">If you mark "yes" to #5, you must be seen by a doctor. College Program can get signed during Sports Physical appointment. Scholarship students get signed when at doctor for Report of Medical History.</p> <p style="text-align: center;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>
<p>6. Does either of the following apply to you?</p> <ul style="list-style-type: none"> - Age 35 or older. - A family history of sudden death before the age of 50. <p>NOTE: If "Yes", proceed to question 7. If "No", STOP. Print and Sign PARFQ. You may take the PRT.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>7. Have you been physically INACTIVE?</p> <p>"Inactive" means participating in less than 30 minutes of vigorous activity per session, 3 days per week over the last 3 months. "Vigorous activity" is defined as sweating and moderate to heavy increases in breathing and heart rate.</p> <p>NOTE: If "Yes", proceed to question 8. If "No", STOP. Print and Sign PARFQ. You may take the PRT.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>8. Does one (1) or more of the following apply to you?</p> <ul style="list-style-type: none"> - Used any tobacco products in the last 30 days. - Diabetes. - High Blood Pressure that is not controlled. - Family history of heart disease at any age. - You are male and over 45 years of age OR you are female and over 55 years of age. <p>NOTE: If "Yes", STOP. Save, Print, and Sign PARFQ. AMDR/HCP must review your current PHA before you may take the PRT. If "No", Print and Sign PARFQ. You may take the PRT.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Member Name (<i>Last, First, MI</i>):	PARFQ Date:	Date of Birth:	Date of Last PHA:	Member Signature (CAC Digital Signature Optional):
				

PRT PARTICIPATION STATUS	Date you fill out this form	Date of DODMERB Physical or Sports Physical
<input type="checkbox"/> Member Cleared Waiver NOT Required	<input type="checkbox"/> Member Cleared Waiver Required	<input type="checkbox"/> Member NOT Cleared Waiver Required

HCP/AMDR Name (<i>Print</i>):	HCP/AMDR Signature:	Date:

REPORT OF MEDICAL HISTORY

OMB No. 0704-0413
OMB approval expires
Aug 31, 2014

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the 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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 1155 Defense Pentagon, Washington, DC 20301-1155 (0704-0413). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, DoD Instruction 6130.03, and E.O. 9397, as amended (SSN).

PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening form (DD 2807-2). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted. Completed forms are covered by recruiting, medical evaluation board, and official military personnel file SORNs maintained by each of the Services.

ROUTINE USE(S): The Blanket Routine Uses found at http://privacy.defense.gov/blanket_uses.shtml apply to this collection.

DISCLOSURE: Voluntary. However, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) Burke, Arleigh, Albert	2. SOCIAL SECURITY NUMBER N/A	3. TODAY'S DATE (YYYYMMDD) 20160522
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code) 123 Main St. Boulder, CO 80303	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code) College Program students fill this out as part of College Program application but since this is required yearly, fill out again and get signed during Sports Physical. Scholarship students need to go to a family doctor to complete.	
b. HOME TELEPHONE (Include Area Code) 303-123-4567		

X ALL APPLICABLE BOXES:			7.a. POSITION (Title, Grade, Component) MIDN 4/C
6.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input checked="" type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	6.b. COMPONENT <input type="checkbox"/> Regular <input checked="" type="checkbox"/> Reserve <input type="checkbox"/> National Guard	6.c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input checked="" type="checkbox"/> Separation <input checked="" type="checkbox"/> ROTC Scholarship Program	7.b. USUAL OCCUPATION NROTC Student

8. CURRENT MEDICATIONS (Prescription and Over-the-counter) Brevoxyl, Daily multi-vitamin	9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance) Shellfish allergy
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Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	12. (Continued)	YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input checked="" type="radio"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input checked="" type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input checked="" type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<input type="radio"/>	<input type="radio"/>	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input type="radio"/>	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (cracked or fractured)	<input checked="" type="radio"/>	<input type="radio"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input checked="" type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	c. Currently in good health (If no, explain in Item 29 on Page 2.)	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>	d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) Burke, Arleigh, Albert	SOCIAL SECURITY NUMBER N/A
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Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	YES	NO
15.a. Dizziness or fainting spells	<input type="radio"/>	<input type="radio"/>		
b. Frequent or severe headache	<input type="radio"/>	<input type="radio"/>		
c. A head injury, memory loss or amnesia	<input type="radio"/>	<input type="radio"/>		
d. Paralysis	<input type="radio"/>	<input type="radio"/>		
e. Seizures, convulsions, epilepsy or fits	<input type="radio"/>	<input type="radio"/>		
f. Car, train, sea, or air sickness	<input type="radio"/>	<input type="radio"/>		
g. A period of unconsciousness or concussion	<input type="radio"/>	<input type="radio"/>		
h. Meningitis, encephalitis, or other neurological problems	<input type="radio"/>	<input type="radio"/>		
16.a. Rheumatic fever	<input type="radio"/>	<input type="radio"/>		
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)	<input type="radio"/>	<input type="radio"/>		
c. Pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>		
d. Palpitation, pounding heart or abnormal heartbeat	<input type="radio"/>	<input type="radio"/>		
e. Heart trouble or murmur	<input type="radio"/>	<input type="radio"/>		
f. High or low blood pressure	<input type="radio"/>	<input type="radio"/>		
17.a. Nervous trouble of any sort (anxiety or panic attacks)	<input type="radio"/>	<input type="radio"/>		
b. Habitual stammering or stuttering	<input type="radio"/>	<input type="radio"/>		
c. Loss of memory or amnesia, or neurological symptoms	<input type="radio"/>	<input type="radio"/>		
d. Frequent trouble sleeping	<input type="radio"/>	<input type="radio"/>		
e. Received counseling of any type	<input type="radio"/>	<input type="radio"/>		
f. Depression or excessive worry	<input type="radio"/>	<input type="radio"/>		
g. Been evaluated or treated for a mental condition	<input type="radio"/>	<input type="radio"/>		
h. Attempted suicide	<input type="radio"/>	<input type="radio"/>		
i. Used illegal drugs or abused prescription drugs	<input type="radio"/>	<input type="radio"/>		
18. FEMALES ONLY. Have you ever had or do you now have:				
a. Treatment for a gynecological (female) disorder	<input type="radio"/>	<input type="radio"/>		
b. A change of menstrual pattern	<input type="radio"/>	<input type="radio"/>		
c. Any abnormal PAP smears	<input type="radio"/>	<input type="radio"/>		
d. First day of last menstrual period (YYYYMMDD)				
e. Date of last PAP smear (YYYYMMDD)				
19. Have you been refused employment or been unable to hold a job or stay in school because of:				
a. Sensitivity to chemicals, dust, sunlight, etc.	<input type="radio"/>	<input type="radio"/>		
b. Inability to perform certain motions	<input type="radio"/>	<input type="radio"/>		
c. Inability to stand, sit, kneel, lie down, etc.	<input type="radio"/>	<input type="radio"/>		
d. Other medical reasons (If yes, give reasons.)	<input type="radio"/>	<input type="radio"/>		
20. Have you ever been treated in an Emergency Room? (If yes, for what?)	<input type="radio"/>	<input type="radio"/>		
21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	<input type="radio"/>	<input type="radio"/>		
22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.)	<input type="radio"/>	<input type="radio"/>		
23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	<input type="radio"/>	<input type="radio"/>		
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)	<input type="radio"/>	<input type="radio"/>		
25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.)	<input type="radio"/>	<input type="radio"/>		
26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)	<input type="radio"/>	<input type="radio"/>		
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.)	<input type="radio"/>	<input type="radio"/>		
28. Have you ever been denied life insurance?	<input type="radio"/>	<input type="radio"/>		

29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)

12n. Fractured radius and ulna February 2007. Healed without complication.
 13g. Adolescent Acne - Face/Back. Currently taking medication.

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name Burke, Arleigh, Albert Date of birth 10/19/01

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

This form is only required for College Program Students or for scholarship students not yet physically qualified by DODMERB (pending waiver).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP	/ (/)	Pulse	Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
VISION		R 20/	L 20/
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart ^a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) ^b			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic ^c			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

- Not cleared
- Pending further evaluation
- For any sports
- For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name Burke, Arleigh, Albert Sex M F Age 114 Date of birth 10/19/01

Cleared for all sports without restriction
 Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

Not cleared
 Pending further evaluation
 For any sports
 For certain sports _____
Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete.

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____

IMPORTANT: THIS IS A LEGAL DOCUMENT

Please read and understand this document before signing. If you have any questions, please ask us or consult an attorney.

The Naval Reserve Officers Training Corps ("NROTC") Unit, University of Colorado Boulder, hereinafter, the "NROTC UNIT") and its staff have done everything possible to ensure active students currently attending the University of Colorado experience an introduction to military service. To this end, we have allowed current students to participate in evolutions designed to prepare them professionally and physically for the rigors of military training; this program is hereinafter referred to as the "Physical Training Program." You are advised that the Physical Training Program is not risk free. The same elements that contribute to the unique character and fun of the Physical Training Program, such as physical challenge and exertion, can cause loss or damage to equipment, and injury, illness or in extreme cases, permanent trauma or death to you or others. We do not want to heighten or reduce your enthusiasm for the experience, but we do want you to know in advance what to expect, and to be informed of some of the possible risks. You must read, sign, and return this document to our office before participating in the Physical Training Program.

PHYSICAL TRAINING PROGRAM ACKNOWLEDGMENT OF RISK

The Physical Training Program may consist of the following activities: pull-ups and push-ups (upper body conditioning), rope climbs, calisthenics, abdominal exercises, distance running, endurance running (including runs with weighted packs and/or boots/utility runs and/or obstacle/confidence courses), hiking (with and without weighted packs), timed track work-outs, mock physical fitness examinations, combat conditioning exercises/drills (low crawl, fireman's carry, bear crawl, commando crawl, etc.), plyometrics, log drills (carrying logs while running/hiking), , weight training, and circuit training, . The Physical Training Program may also consist of field training exercises, such as land navigation/orienteering, fire team/squad formations and field trips to locations of interest to future Navy and Marine Corps officers. It is noted that participation in the foregoing activities may involve transportation to and from the NROTC UNIT.

Participation in any or all of the activities stated above may result in bodily injury, disease, strains, fractures, partial and/or total paralysis, other ailments that could cause serious disability or death. It is also possible that some participants would suffer mental anguish or trauma from the experience or their injuries.

The foregoing list is not an exclusive or exhaustive statement of possible injuries, trauma, or accidents that may occur while participating in the Physical Training Program. Most of these injuries are rare, and you are not likely to encounter them; however, they have occurred, and you need to know about them and other possible injuries not mentioned above. These injuries occur more often when participants are using drugs or alcohol or not physically able to undertake the Physical Training Program.

CONTRACT, WAIVER, RELEASE AND INDEMNIFICATION

I certify that I am fully capable of participating in the Physical Training Program and that I have read the above statement on some of the possible risks associated with the Physical Training Program. Accordingly, I assume full responsibility for bodily injury, death, loss of personal property and any expenses as a result of my negligence, the negligence of another participant on the trip/program or activity, or the negligence of the NROTC UNIT and its staff. I also understand that the NROTC UNIT reserves the right to refuse any person it judges to be incapable of meeting the rigors and requirements of participating in the Physical Training Program. I am in good physical condition and able to undertake this activity.

PLEASE READ OTHER SIDE

Page 1 of 3

Enclosure (9)

I, on behalf of myself, my family, and my heirs and assigns, agree to indemnify and hold harmless the NROTC UNIT, its staff, and the United States of America, the Department of the Navy, and its members, agents and employees from all claims, damages, losses, injuries and expenses arising out of or resulting from my participation in the Physical Training Program, including all claims, damages, losses, injuries and expenses arising out of or resulting from my transportation to and from the activities of the Physical Training Program. I further agree to release, acquit and covenant not to sue the NROTC UNIT, its staff, and the United States of America, the Department of the Navy, and its members, agents and employees for all actions, causes of action, claims or damages, damages in law or remedies in equity of whatever kind, including the negligence of the NROTC UNIT and its staff. In short, my family members, heirs, assigns and I cannot sue the NROTC UNIT, its staff, and the United States of America, the Department of the Navy, and its members, agents and employees, and if I or they do, we cannot collect any money.

I agree to the site of any lawsuit and the law governing any such lawsuit shall be governed under the Federal Tort Claims Act, Military Claims Act, Foreign Claims Act, Suits in Admiralty Act, Public Vessels Act or Admiralty Extension Act, which ever is applicable. The terms of this agreement shall continue and be in effect after the Physical Training Program has ended.

As liquidated damages, I hereby agree that if the NROTC UNIT is forced to defend any action, lawsuit or litigation by myself, my executors, or my heirs, on my family's or my behalf, my heirs or executors and I shall pay court costs and attorney fees if such defense is successful.

Should a court of competent jurisdiction declare any paragraph or part of this agreement unenforceable, the remaining parts or paragraphs shall remain in full force and effect. A copy of this agreement can be used as if it were an original.

I authorize and release to the NROTC UNIT and its staff the use of my image in any photograph or video recording for any purpose of the NROTC UNIT.

I have adequate health, disability and life insurance.

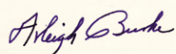
I hereby give permission for transportation to any medical facility or hospital, and I authorize the rendering of necessary emergency medical care for me by medical personnel and/or the NROTC UNIT. I hereby authorize the release of any medical information, including information concerning my HIV or "AIDS" status, in the possession of the NROTC UNIT to any medical facility, hospital, ambulance, first aid provider, first aid service, doctor, nurse or other such person rendering care on my behalf. I hereby waive any action or claim against the NROTC UNIT and its staff, or any health care provider, hospital, doctor, nurse or first aid provider for the release of this medical information including my HIV or "AIDS" status.

I, Arleigh A. Burke, of my own free will, for my heirs and executors and myself, have read this agreement in its entirety and fully understand and acknowledge the risks and liability involved from my participation in the Physical Training Program this 23rd day of May 2016.

[AAB] I have no medical condition that would prevent my participation in this activity (initial).

I have read and understood this agreement.

PARTICIPANT SIGNATURE



If under the age of 18, a guardian must sign.

PRINTED NAME

Arleigh A. Burke

ADDRESS

123 Main St., Boulder, CO, 80303

PHONE: (303) 123 - 4567

EMERGENCY POINT OF CONTACT

Oscar Burke

NAME

Father

RELATIONSHIP

PHONE: (303) 123 - 7654

MEDICAL INSURANCE

Metlife

PROVIDER/INSURER

12-3456789-0

GROUP/POLICY NUMBER

PHONE: (800) 638 - 5433

BURDEN ESTIMATE STATEMENT

The estimated average burden associated with this collection of information is 10 minutes per respondent or recordkeeper, depending on individual circumstances. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Financial Management Service, Facilities Management Division, Property & Supply Section, Room B-101, 3700 East-West Highway, Hyattsville, MD 20782 or the Office of Management and Budget, Paperwork Reduction Project (1510-0007), Washington, D.C. 20503.

PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

INFORMATION FOUND ON CHECKS

Most of the information needed to complete boxes A, C, and F in Section 1 is printed on your government check:

- (A) Be sure that payee's name is written exactly as it appears on the check. Be sure current address is shown.
- (C) Claim numbers and suffixes are printed here on checks beneath the date for the type of payment shown here. Check the Green Book for the location of prefixes and suffixes for other types of payments.
- (F) Type of payment is printed to the left of the amount.

United States Treasury 15-51
000
AUSTIN, TEXAS

Month Day Year
08 31 84

Check No.
0000 415785

Pay to the order of

00 C

28 28

DOLLARS CTS
\$****100 00

A

F

NOT NEGOTIABLE

:00000518' 041571926'

SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete a new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than \$10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.

RECORD OF EMERGENCY DATA

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC 552, 10 USC 655, 1475 to 1480 and 2771, 38 USC 1970, 44 USC 3101, and EO 9397 (SSN).

PRINCIPAL PURPOSES: This form is used by military personnel and Department of Defense civilian and contractor personnel, collectively referred to as civilians, when applicable. For military personnel, it is used to designate beneficiaries for certain benefits in the event of the Service member's death. It is also a guide for disposition of that member's pay and allowances if captured, missing or interned. It also shows names and addresses of the person(s) the Service member desires to be notified in case of emergency or death. For civilian personnel, it is used to expedite the notification process in the event of an emergency and/or the death of the member. The purpose of soliciting the SSN is to provide positive identification. All items may not be applicable.

ROUTINE USES: None.

DISCLOSURE: Voluntary; however, failure to provide accurate personal identifier information and other solicited information will delay notification and the processing of benefits to designated beneficiaries if applicable.

INSTRUCTIONS TO SERVICE MEMBER

This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty (other family members or fiancé), and, to designate beneficiaries for certain benefits if you die. IT IS YOUR RESPONSIBILITY to keep your Record of Emergency Data up to date to show your desires as to beneficiaries to receive certain death payments, and to show changes in your family or other personnel listed, for example, as a result of marriage, civil court action, death, or address change.

INSTRUCTIONS TO CIVILIANS

This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty. Not every item on this form is applicable to you. **This form is used by the Department of Defense (DoD) to expedite notification in the case of emergencies or death.** It does not have a legal impact on other forms you may have completed with the DoD or your employer.

IMPORTANT: This form is divided into two sections: Section 1 - Emergency Contact Information and Section 2 - Benefits Related Information. **READ THE INSTRUCTIONS ON PAGES 3 AND 4 BEFORE COMPLETING THIS FORM.**

SECTION 1 - EMERGENCY CONTACT INFORMATION

1. NAME (Last, First, Middle Initial)

Burke, Arleigh, A.

2. SSN

N/A

3a. SERVICE/CIVILIAN CATEGORY

ARMY NAVY MARINE CORPS AIR FORCE DoD CIVILIAN CONTRACTOR

b. REPORTING UNIT CODE/DUTY STATION

63214 (use this number here)

4a. SPOUSE NAME (If applicable) (Last, First, Middle Initial)

SINGLE DIVORCED WIDOWED

b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER

123 Main St.
Boulder, CO 80303

5. CHILDREN

a. NAME (Last, First, Middle Initial)

b. RELATIONSHIP

c. DATE OF BIRTH (YYYYMMDD)

d. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER

6a. FATHER NAME (Last, First, Middle Initial)

Burke, Oscar, B.

b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER

123 Main St., Boulder, CO, 80303 (303)123-7654

7a. MOTHER NAME (Last, First, Middle Initial)

Burke, Clara, F.

b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER

123 Main St., Boulder, CO, 80303 (303)123-4321

8a. DO NOT NOTIFY DUE TO ILL HEALTH

b. NOTIFY INSTEAD

9a. DESIGNATED PERSON(S) (Military only)

b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER

10. CONTRACTING AGENCY AND TELEPHONE NUMBER (Contractors only)

SECTION 2 - BENEFITS RELATED INFORMATION

11a. BENEFICIARY(IES) FOR DEATH GRATUITY <i>(Military only)</i>	b. RELATIONSHIP	c. ADDRESS <i>(Include ZIP Code)</i> AND TELEPHONE NUMBER	d. PERCENTAGE
Burke, Oscar, B.	Father	123 Main St., Boulder, CO, 80303 (303)123-4321	50%
Burke, Clara, F.	Mother	123 Main St., Boulder, CO, 80303 (303)123-4321	50%
12a. BENEFICIARY(IES) FOR UNPAID PAY/ALLOWANCES <i>(Military only)</i> NAME AND RELATIONSHIP		b. ADDRESS <i>(Include ZIP Code)</i> AND TELEPHONE NUMBER	c. PERCENTAGE
Burke, Oscar, B. - Father		123 Main St., Boulder, CO, 80303 (303)123-4321	50%
Burke, Clara, F. - Mother		123 Main St., Boulder, CO, 80303 (303)123-4321	50%
13a. PERSON AUTHORIZED TO DIRECT DISPOSITION (PADD) <i>(Military only)</i> NAME AND RELATIONSHIP		b. ADDRESS <i>(Include ZIP Code)</i> AND TELEPHONE NUMBER	
Burke, Oscar, B. - Father		123 Main St., Boulder, CO, 80303 (303)123-4321 50%	
Burke, Clara, F. - Mother		123 Main St., Boulder, CO, 80303 (303)123-4321 50%	
14. CONTINUATION/REMARKS			
15. SIGNATURE OF SERVICE MEMBER/CIVILIAN <i>(Include rank, rate, or grade if applicable)</i>	16. SIGNATURE OF WITNESS <i>(Include rank, rate, or grade as appropriate)</i>		17. DATE SIGNED <i>(YYYYMMDD)</i>
Don't sign yet. Will be sign when you arrive.			

INSTRUCTIONS FOR PREPARING DD FORM 93

(See appropriate Service Directives for supplemental instructions for completion of this form at other than MEPS)

All entries explained below are for electronic or typewriter completion, except those specifically noted. If a computer or typewriter is not available, print in black or blue-black ink insuring a legible image on all copies. Include "Jr.," "Sr.," "III" or similar designation for each name, if applicable. When an address is entered, include the appropriate ZIP Code. If the member cannot provide a current address, indicate "unknown" in the appropriate item. Addresses shown as P.O. Box Numbers or RFD numbers should indicate in Item 14, "Continuations/Remarks", a street address or general guidance to reach the place of residence. In addition, the notation "See Item 14" should be included in the item pertaining to the particular next of kin or when the space for a particular item is insufficient. If the address for the person in the item has been shown in a preceding item, it is unnecessary to repeat the address; however, the name must be entered. Those items that are considered not applicable to civilians will be left blank.

ITEM 1. Enter full last name, first name, and middle initial.

ITEM 2. Enter social security number (SSN).

ITEM 3a. Service. **Military:** Mark X in appropriate block. **Civilian:** Mark two blocks as appropriate. Examples: an Army civilian would mark Army and either Civilian or Contractor; a DoD civilian, without affiliation to one of the Military Services, would mark DoD and then either Civilian or Contractor as appropriate.

ITEM 3b. Reporting Unit Code/Duty Station. See Service Directives.

ITEM 4a. Spouse Name. Enter last name (if different from Item 1), first name and middle initial on the line provided. If single, divorced, or widowed, mark appropriate block.

ITEM 4b. Address and Telephone Number. Enter the "actual" address and telephone number, not the mailing address. Include civilian title or military rank and service if applicable. If one of the blocks in 4a is marked, leave blank.

ITEM 5a-d. Children. Enter last name (only if different from Item 1) first name and middle initial, relationship, and date of birth of all children. If none, so state. Include illegitimate children if acknowledged by member or paternity/maternity has been judicially decreed. Relationship examples: son, daughter, stepson or daughter, adopted son or daughter or ward. Date of birth example: 19950704. For children not living with the member's current spouse, include address and name and relationship of person with whom residing in item 5d.

ITEM 6a. Father Name. Last name, first name and middle initial.

ITEM 6b. Address and Telephone Number of Father. If unknown or deceased, so state. Include civilian title or military rank and service if applicable. If other than natural father is listed, indicate relationship.

ITEM 7a. Mother Name. Last name, first name and middle initial.

ITEM 7b. Address and Telephone Number of Mother. If unknown or deceased, so state. Include civilian title or military rank and service if applicable. If other than natural mother is listed, indicate relationship.

ITEM 8. Persons Not to be Notified Due to Ill Health.

a. List relationship, e.g., "Mother," of person(s) listed in Items 4, 5, 6, or 7 who are not to be notified of a casualty due to ill health. If more than one child, specify, e.g., "daughter Susan." Otherwise, enter "None".

b. List relationship, e.g., "Father" or name and address of person(s) to be notified in lieu of person(s) listed in item 8a. If "None" is entered in Item 8a, leave blank.

ITEM 9a. This item will be used to record the name of the person or persons, if any, other than the member's primary next of kin or immediate family, to whom information on the whereabouts and status of the member shall be provided if the member is placed in a missing status. Reference 10 USC, Section 655. **NOT APPLICABLE to civilians.**

ITEM 9b. Address and telephone number of Designated Person(s). **NOT APPLICABLE to civilians.**

ITEM 10. Contracting Agency and Telephone Number (**Contractors only**). **NOT APPLICABLE to military personnel.** Civilian contractors will provide the name of their contracting agency and its telephone number. Example: XYZ Electric, (703) 555-5689. The telephone number should be to the company or corporation's personnel or human resources office.

ITEM 11a. Beneficiary(ies) for Death Gratuity (**Military only**). Enter first name(s), middle initial, and last name(s) of the person(s) to receive death gratuity pay. A member may designate one or more persons to receive all or a portion of the death gratuity pay. The designation of a person to receive a portion of the amount shall indicate the percentage of the amount, to be specified only in 10 percent increments, that the person may receive. If the member does not wish to designate a beneficiary for the payment of death gratuity, enter "None," or if the full amount is not designated, the payment or balance will be paid as follows:

- (1) To the surviving spouse of the person, if any;
- (2) To any surviving children of the person and the descendants of any deceased children by representation;
- (3) To the surviving parents or the survivor of them;
- (4) To the duly appointed executor or administrator of the estate of the person;
- (5) If there are none of the above, to other next of kin of the person entitled under the laws of domicile of the person at the time of the person's death.

The member should make specific designations, as it expedites payment.

INSTRUCTIONS FOR PREPARING DD FORM 93

(Continued)

ITEM 11a. (Continued) Seek legal advice if naming a minor child as a beneficiary. If a member has a spouse but designates a person other than the spouse to receive all or a portion of the death gratuity pay, the Service concerned is required to provide notice of the designation to the spouse. **NOT APPLICABLE to civilians.**

Item 11b. Relationship. **NOT APPLICABLE to civilians.**

ITEM 11c. Enter beneficiary(ies) full mailing address and telephone number to include the ZIP Code. **NOT APPLICABLE to civilians.**

ITEM 11d. Show the percentage to be paid to each person. Enter 10%, 20%, 30%, up to 100% as appropriate. The sum shares must equal 100 percent. If no percent is indicated and more than one person is named, the money is paid in equal shares to the persons named. **NOT APPLICABLE to civilians.**

ITEM 12a. Beneficiary(ies) for Unpaid Pay/Allowance (**Military only**). Enter first name(s), middle initial, last name(s) and relationship of person to receive unpaid pay and allowances at the time of death. The member may indicate anyone to receive this payment. If the member designated two or more beneficiaries, state the percentage to be paid each in item 10c. If the member does not wish to designate a beneficiary, enter "By Law." The member is urged to designate a beneficiary for unpaid pay and allowances as payment will be made to the person in order of precedence by law (10 USC 2771) in the absence of a designation. Seek legal advice if naming a minor child as beneficiary. **NOT APPLICABLE to civilians.**

ITEM 12b. Enter beneficiary(ies) full mailing address and telephone number to include the ZIP Code. **NOT APPLICABLE to civilians.**

ITEM 12c. If the member designated two or more beneficiaries, state the percentage to be paid each in this section. The sum shares must equal 100 percent. **NOT APPLICABLE to civilians.**

ITEM 13a. Enter the name and relationship of the Person Authorized to Direct Disposition (PADD) of your remains should you become a casualty. Only the following persons may be named as a PADD: surviving spouse, blood relative of legal age, or adoptive relatives of the decedent. If neither of these three can be found, a person standing in loco parentis may be named. **NOT APPLICABLE to civilians.**

ITEM 13b. Address and telephone number of PADD. **NOT APPLICABLE to civilians.**

ITEM 14. Continuations/Remarks. Use this item for remarks or continuation of other items, if necessary. Prefix entry with the number of the item being continued; for example, 5/John J./son/ 19851220/321 Pecan Drive, Schertz TX 78151. Also use this item to list name, address, and relationship of other persons the member desires to be notified. Other dependents may also be listed. This block offers the greatest amount of flexibility for the member to record other important information not otherwise requested but considered extremely useful in the casualty notification and assistance process. Besides continuing information from other blocks on this form, the member may desire to include additional information such as: NOK language barriers, location or existence of a Will, additional private insurance information, other family member contact numbers, etc. If additional space is required, attach a supplemental sheet of standard bond paper with the information.

ITEM 15. Signature of Service Member/Civilian. Check and verify all entries and sign all copies in ink as follows: First name, middle initial, last name. Include rank, rate, or grade if applicable. May be electronically signed (see DoD Instruction 1300.18 for guidelines).

ITEM 16. Signature of Witness. Have a witness (disinterested person) sign all copies in ink as follows: First name, middle initial, last name. Include rank, rate, or grade as appropriate. A witness signature is not required for electronic versions of the DD Form 93 (see DoD Instruction 1300.18).

ITEM 17. Date the member or civilian signs the form. This item is an ink entry and must be completed on all copies.



Prudential

Office of Servicemembers'
Group Life Insurance

Print Form

Save Completed Form

Clear Form

Servicemembers' Group Life Insurance Election and Certificate

1. About You

Arleigh, Arnold, Burke Print Name (First, Middle, Last)	MIDN 4/C Rank, title or grade	N/A Social Security Number
University of Colorado Naval ROTC Duty Location	Navy or Marine Branch of Service	\$400,000 Current Amount of SGLI

2. About Your Coverage

I am completing this form to: (Check all that apply)

- Name or update my SGLI beneficiary. You must complete sections 3 & 5.
- Increase or restore my SGLI coverage to \$ _____. You must complete sections 3, 4, & 5.
- Reduce my SGLI coverage to \$ _____. You must complete sections 3 & 5.
- Decline or cancel SGLI coverage. Write below "I do not want insurance at this time." You must complete section 5.
" _____ "

Coverage is available in increments of \$50,000 up to a maximum of \$400,000

3. About Your Beneficiaries Complete this section unless you are declining coverage

Primary Name and Address	Social Security Number (If available)	Relationship to you	Share to each (% or \$ amounts)	Payment Option (Lump sum* or 36 equal monthly payments)
1. Oscar B. Burke	□□□□ N/A □□□□	Father	50%	Lump Sum
2. Clara F. Burke	□□□□ N/A □□□□	Mother	50%	Lump Sum
3.	□□□□ □□ □□□□			
4.	□□□□ □□ □□□□			
Secondary				
1.	□□□□ □□ □□□□			
2.	□□□□ □□ □□□□			
3.	□□□□ □□ □□□□			
4.	□□□□ □□ □□□□			

Have more beneficiaries? Check the box and complete Supplemental SGLI Beneficiary Form, SGLV 8286S.

If you do not name beneficiaries above, your insurance will be paid by law (see page 3).

* If the insured member elects a lump sum payment, the beneficiary(ies) will be given the option of receiving the lump sum payment through the Prudential Alliance Account®, by check, or Electronic Funds Transfer (EFT). Alliance Account is not available for payments less than \$5,000, payments to individuals residing outside the United States and its territories, and certain other payments. These will be paid by check.

Open Solutions Inc. is the Service Provider of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Draft clearing and processing support is provided by UMB Bank, N.A. **Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC).** Open Solutions Inc. and UMB Bank, N.A. are not Prudential financial companies.

4. About Your Health Complete this section *ONLY* if you are restoring or increasing coverage.

10/19,1901
Your date of birth (MM, DD, YYYY)

160
Your weight

72
Your height

Your gender Female
 Male

Have you had, been treated for, or had known indications of:

- | | | |
|--|--------------------------|-------------------------------------|
| | Yes | No |
| a. A heart condition? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. High blood pressure? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| c. A neurological disorder? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| d. Diabetes? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| e. Cancer or tumors? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| f. Have you ever been diagnosed as having a disease of the immune system? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| g. Do you have any known physical impairments, deformities, or ill health not covered above? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Did you answer "YES" to any question? If so, reference the question by letter and list date, duration and details below.

Any request to increase coverage does not take effect until approved by the Office of Servicemembers' Group Life Insurance (OSGLI).

5. Your Signature You must complete this section.

I have read the instructions and understand that:

- This form cancels any prior beneficiary or payment instructions.
- I can have SGLI and Veterans' Group Life Insurance (VGLI) coverage at the same time, but the combined amount cannot be more than \$400,000.
- Reducing or declining SGLI coverage can affect the amount of my family coverage, traumatic injury coverage and post-separation coverage (see instructions for details).
- If I am married or get married after completing this form and have not declined SGLI, Family SGLI automatically covers my spouse. I must register my spouse in DEERS so my branch of service can deduct premiums from my pay. *Failure to register my spouse in DEERS will result in my owing debts for unpaid premiums.* I can decline Family SGLI coverage by completing SGLV 8286A.
- I am free to name anyone I want as my beneficiary. I certify that I understand if I have designated someone other than my spouse or child as my beneficiary, the person I have named is the person I intend to receive my insurance proceeds. I also understand that if I am married, my spouse may be notified that he/she (or my child) is not my designated beneficiary.
- I certify that the information provided on this form is true and correct to the best of my knowledge and belief. Any deception or knowingly false statement either by inference or omission may result in cancellation of the insurance or in the refusal to pay a claim.

Wait to sign upon check-in.		Wait until check-in.
Service Member Signature	Social Security Number	Date (MM, DD, YYYY)

123 Main St., Boulder, CO 80303

Address

Submit this form to your Unit Personnel Clerk.

For Branch of Service Use Only	For OSGLI Use Only
Name of Personnel Clerk	Representative
Rank, title or grade	Approve
Contact telephone/email	Disapprove
Date	Date
Address	

Information for the Service Member

About your SGLI Coverage

Servicemembers' Group Life Insurance (SGLI) is granted under title 38, United States Code, and is subject to the provisions of that title and its amendments, and title 38 Code of Federal Regulations.

The following charts provide information you should review before naming a beneficiary or selecting a payment option.

Naming Beneficiaries who will receive the insurance

If you...	Then...
are married and decline coverage upon entry into service	Your spouse will be notified that you declined coverage.
are married and designate any person other than your spouse or child for any amount of insurance	Your spouse will be notified in writing that he/she or your child is not the named beneficiary, unless: – your spouse has been previously notified, OR – your spouse is not designated as beneficiary for any amount of insurance prior to the new election.
are married and your spouse is designated as beneficiary and you decline coverage or elect less than maximum coverage, and that election reduces your coverage from the automatic maximum or from a previously elected amount of coverage	Your spouse will be notified in writing of your election to decline or reduce coverage.
have any life event such as marriage, divorce, or children after completing this form	You should complete a new beneficiary form. Beneficiaries are not automatically changed by life events.
name more than one beneficiary	The sum of the shares must equal 100% or the full dollar amount of your insurance.
want to name more than four primary or secondary beneficiaries	You must complete the SGLI Supplemental Beneficiary Form, SGLV 8286S.
name minors as beneficiaries	<ul style="list-style-type: none"> ▪ SGLI will pay the insurance benefit to the court-appointed guardian of the children's estate if the beneficiary is a minor at time of claim. ▪ You can establish a trust for the benefit of the children and name the trust as beneficiary. A trust names a trustee of your choice to be legally responsible for administering the insurance proceeds for the children. ▪ Naming a trust as a beneficiary on this form does NOT create a trust.
name more than one primary beneficiary and one or more of them predeceases you	SGLI will pay the shares equally among the remaining primary beneficiaries.
want to name a Trust as a beneficiary	You must create a trust. Please consult with a military attorney, professional financial planner, or estate planner to help you create Trust documents. (Please note: Trust documents are not needed until a claim is submitted.)
have no surviving primary beneficiaries	SGLI will divide the insurance benefit among the secondary beneficiaries.
do not name a beneficiary or there are no surviving primary or secondary beneficiaries OR indicate that payment should be made by law	SGLI will pay the insurance benefit in the following order: <ol style="list-style-type: none"> 1. Widow or widower 2. Children in equal shares (the share of any deceased child will be distributed equally among the descendants of that child) 3. Parent(s) in equal shares or all to surviving parent 4. A duly appointed executor or administrator of your estate 5. Other next of kin

Payment Options

If you want the beneficiary to...	Then...
receive the insurance proceeds in one lump sum	Write the phrase "lump sum" under Payment Options. If you elect a lump sum payment, your beneficiary(ies) will be given the option of receiving the lump sum payment through the Prudential Alliance Account ^{®*} , by check, or Electronic Funds Transfer (EFT). * Alliance Account is not available for payments less than \$5,000, payments to individuals residing outside the United States and its territories, and certain other payments. These will be paid by check.
receive the insurance proceeds in 36 equal monthly payments	<ul style="list-style-type: none"> ▪ Write "36" under the Payment Option. ▪ Your beneficiary cannot change this payment option.
have a choice	Write the phrase "lump sum" under Payment Option or leave blank.

Instructions for Personnel Clerk and the Service Member

1. A representative of the Uniformed Services must complete the "For Branch of Service Official Use Only" section to indicate receipt of the form from the member after reviewing the following table:

If the service member...	The Personnel Clerk should inform the service member...	Then the Personnel Clerk should...
has just entered the service	he or she is automatically insured for \$400,000 SGLI, unless the service member declines or reduces coverage.	Have the service member designate beneficiaries by completing SGLV 8286.
is increasing or restoring SGLI	he or she must complete Section 4, <i>About Your Health</i> .	<ul style="list-style-type: none"> ■ Approve form if the responses to questions 4a through 4g are "No" and forward the form to payroll to change SGLI premium deductions. ■ Send form to OSGLI if any answer to questions 4a through 4g are "Yes." Only inform payroll when approved by OSGLI.
Reduces, declines, or cancels SGLI	<ul style="list-style-type: none"> ■ an application with health questions is required to increase, elect, or restore coverage at a later date. ■ of the following: <ul style="list-style-type: none"> – the purpose and role of life insurance in financial planning. – the difference between term life insurance and whole life insurance. – the availability of commercial life insurance. – the relationship between SGLI and VGLI. – declining or canceling SGLI will also cancel Family SGLI— both spouse and dependent child coverage— and Traumatic Injury Protection (TSGLI). 	<ul style="list-style-type: none"> ■ Forward the form to payroll to change SGLI premium deductions. ■ If canceling SGLI, have the service member complete SGLV 8286A to end payment of Family SGLI premiums. No form is required to end TSGLI premium deductions. ■ If the member is married and reduces, declines, or cancels SGLI, inform the member that his/her spouse may be notified in writing of the member's election based on Title 38, USC 1967 (f).
is married or gets married after completing this form	<ul style="list-style-type: none"> ■ Family SGLI automatically covers spouse. ■ he or she must register their spouse in DEERS for payroll to deduct premiums. ■ If the member wants to decline coverage or take a lesser amount of spouse coverage, the member must complete SGLV 8286A. 	If applicable, forward the form to payroll to begin premium deductions for the spouse coverage.
has questions about this form	the advice of a military attorney is available at no expense.	Direct them to the appropriate resource.
wants to designate more beneficiaries than the form allows	he or she must complete the Supplemental SGLI Beneficiary Form SGLV 8286S.	Attach the Supplemental Beneficiary Form to the 8286.
designates any person other than his/her spouse or child for any amount of insurance	<ul style="list-style-type: none"> ■ while the member is free to designate anyone he or she chooses as beneficiary, the member must certify that he or she is designating someone other than a spouse or child and the person named will receive the benefit. ■ if the member is married, the member's spouse will be notified in writing that he/she or the member's child is not the named beneficiary, unless: <ul style="list-style-type: none"> – the spouse has been previously notified, OR – the spouse is not designated as beneficiary for any amount of insurance prior to the new election. 	<p>Have the member sign SGLV 8286 to certify that he/she understands that:</p> <ul style="list-style-type: none"> ■ he/she is free to name anyone as beneficiary. ■ if he/she designated someone other than his/her spouse or child as beneficiary, the person the member has named is the person he/she intends to receive the insurance proceeds. ■ if married, the spouse will be notified that he/she (or any child) is not the designated beneficiary.

2. **After the form is completed, Personnel Clerk should:**

- File a copy in the member's official personnel file
- Provide a copy to the service member
- Provide a copy of the form to the payroll office for the member's unit
- Submit the form to OSGLI ONLY if the member is increasing or restoring SGLI coverage and answered "Yes" to one or more of the health questions

OSGLI
 PO Box 41618
 Philadelphia, PA 19176-9913

Questionnaire for National Security Positions

Follow instructions fully or we cannot process your form. If you have any questions, contact the office that gave you the form.

Purpose of this Form

The United States (U.S.) Government conducts background investigations and reinvestigations of persons under consideration for or retention in national security positions as defined in 5 CFR 732 and for positions requiring access to classified information under Executive Order 12968.

Giving us this information is voluntary. If you do not provide each item of requested information, however, we will not be able to complete your investigation, which will adversely affect your eligibility for a national security position. Any information that you provide is evaluated on the basis of its recency, seriousness, relevance to the position and duties, and consistency with all other information about you.

Withholding, misrepresenting, or falsifying information will have an impact on a security clearance, employment prospects, or job status, up to and including denial or revocation of your security clearance, or your removal and debarment from Federal Service.

This form is a permanent document that may be used as the basis for future investigations, security clearance determinations, and determinations of your suitability for employment. Your responses to this form may be compared with previous security questionnaires. It is imperative that the information provided be true and accurate to the best of your knowledge.

Authority to Request this Information

Depending upon the purpose of your investigation, the U.S. Government is authorized to ask for this information under Executive Orders 10450, 10865, 12333, and 12968; sections 3301, 3302, and 9101 of title 5, U.S. Code (U.S.C.); sections 2165 and 2201 of title 42, U.S.C.; chapter 23 of title 50, U.S.C.; and parts 2, 5, 731, 732, and 736 of title 5, Code of Federal Regulations.

Your Social Security Number (SSN) is needed to identify your unique records. Although disclosure of your SSN is not mandatory, failure to disclose your SSN may prevent or delay the processing of your background investigation. The authority for soliciting and verifying your SSN is Executive Order 9397.

The Investigative Process

Background investigations for national security positions are conducted to gather information to show whether you are reliable, trustworthy, of good conduct and character, and loyal to the U.S. The information that you provide on this form may be confirmed during the investigation. The investigation may extend beyond the time covered by this form when necessary to resolve issues. Your current employer may be contacted as part of the investigation, even if you have previously indicated on applications or other forms that you do not want your current employer to be contacted.

In addition to the questions on this form, inquiry also is made about your adherence to security requirements, honesty and integrity, vulnerability to exploitation or coercion, falsification, misrepresentation, and any other behavior, activities, or associations that tend to show the person is not reliable, trustworthy, or loyal. Checks of Federal agency records may be made about your spouse or other cohabitant.

Your Personal Interview

Some investigations will include an interview with you as a routine part of the investigative process. The investigator may ask you to explain your answers to any question on this form. This provides you the opportunity to update, clarify, and explain information on your form more completely, which often helps to complete your investigation faster. It is important that the interview be conducted as soon as possible after you are contacted. Postponements will delay the processing of your investigation, and declining to be interviewed may result in your investigation being delayed or canceled.

For the interview, you will be asked to bring identification with your picture on it, such as a valid state driver's license. There are other documents you may be asked to bring to verify your identity as well. These may include documentation of any legal name change, Social Security card, passport, and/or your birth certificate.

You may also be asked to bring documents about information you provided on the form or about other matters requiring specific attention. These matters include (a) alien registration or naturalization documentation; (b) delinquent loans or taxes, bankruptcies, judgments, liens, or other financial obligations; (c) agreements involving child custody or support, alimony, or property settlements; (d) arrests, convictions, probation, and/or parole; or (e) other matters described in court records.

Special Instructions for Completing this Form

Questions on this form related to residence, employment, and education will require 7 years of information except that Single-Scope Background Investigations (SSBI) will require 10 years of information.

Provide 7 years of information unless you have been instructed to provide 10 years to satisfy SSBI requirements. If you are unsure as to the amount of information to provide, contact the office that gave you this form.

The instructions for these questions specify a 10-year time frame when an SSBI is required. If you have any questions about this investigative request or whether the 7-year time frame or the 10-year time frame applies to your responses to these questions, contact the office that gave you this form.

Instructions for Completing this Form

1. Follow the instructions given to you by the office that gave you this form and any other clarifying instructions furnished by that office to assist you in completion of this form. You must sign and date, in ink, the original and each copy you submit. **You should retain a copy of the completed form for your records.**
2. Type or legibly print your answers in ink (if the form is not legible, it will not be accepted). You may also be asked to submit your form using the approved electronic format.
3. All questions on this form must be answered. If no response is necessary or applicable, indicate this on the form with "N/A" unless otherwise noted.
4. Any changes that you make to this form after you sign it must be initialed and dated by you. Under certain limited circumstances, agencies may modify your response(s) with your consent.
5. You must use the Location codes (abbreviations) listed on the back of this page when you fill out this form. Do not abbreviate the names of cities or foreign countries.
6. Whenever "City (Country)" is shown in an address block, also provide in that block the name of the country when the address is outside the U.S.
7. The 5-digit postal Zip Codes are needed to speed the processing of your investigation. Refer to an automated system approved by the U.S. Postal Service to assist you with Zip Codes.
8. For telephone numbers in the U.S., be sure to include the area code.
9. All dates provided in this form must be in Month/Day/Year or Month/Year format. Use numbers (01-12) to indicate months. For example, July 29, 1968, should be written as 07/29/1968. If you find that you cannot report an exact date, approximate or estimate the date to the best of your ability and indicate this by writing "APPROX." or "EST."
10. If you need additional space for explanation or to list your residences, employment/self-employment/unemployment, or education, you should use a continuation sheet, SF 86A. If additional space is needed to answer other items, use the Continuation Space on page 17 or a blank sheet(s) of paper. Each blank sheet of paper you use must contain your name and SSN at the top of the page.

Final Determination on Your Eligibility

Final determination on your eligibility for a national security position is the responsibility of the Federal agency that requested your investigation. You will be provided the opportunity personally to explain, refute, or clarify any information before a final decision is made.

QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

Penalties for Inaccurate or False Statements

The U.S. Criminal Code (title 18, section 1001) provides that knowingly falsifying or concealing a material fact is a felony which may result in fines and/or up to 5 years of imprisonment. In addition, Federal agencies generally fire, do not grant a security clearance, or disqualify individuals who have

materially and deliberately falsified these forms, and this remains a part of the permanent record for future placements. Your prospects of placement or security clearance are better if you answer all questions truthfully and completely. You will have adequate opportunity to explain any information you give to us on this form and to make your comments part of the record.

DISCLOSURE INFORMATION

The information you give to us is for the purpose of investigating you for a national security position; we will protect it from unauthorized disclosure. The collection, maintenance, and disclosure of background investigative information is governed by the Privacy Act. The agency that requested the investigation and the agency that conducted the investigation have published notices in the Federal Register describing the systems of records in which

your records will be maintained. The information on this form, and information collected during an investigation, may be disclosed without your consent by an agency maintaining the information in a system of records as permitted by the Privacy Act [5 U.S.C. 552a(b)], and by routine uses published by the agency in the Federal Register. The office that gave you this form will provide you a copy of its routine uses.

PRIVACY ACT ROUTINE USES

1. To the Department of Justice when: (a) the agency or any component thereof; or (b) any employee of the agency in his or her official capacity; or (c) any employee of the agency in his or her individual capacity where the Department of Justice has agreed to represent the employee; or (d) the United States Government, is a party to litigation or has interest in such litigation, and by careful review, the agency determines that the records are both relevant and necessary to the litigation and the use of such records by the Department of Justice is therefore deemed by the agency to be for a purpose that is compatible with the purpose for which the agency collected the records.
2. To a court or adjudicative body in a proceeding when: (a) the agency or any component thereof; or (b) any employee of the agency in his or her official capacity; or (c) any employee of the agency in his or her individual capacity where the Department of Justice has agreed to represent the employee; or (d) the United States Government is a party to litigation or has interest in such litigation, and by careful review, the agency determines that the records are both relevant and necessary to the litigation and the use of such records is therefore deemed by the agency to be for a purpose that is compatible with the purpose for which the agency collected the records.
3. Except as noted in Question 23 and 27, when a record on its face, or in conjunction with other records, indicates a violation or potential violation of law, whether civil, criminal, or regulatory in nature, and whether arising by general statute, particular program statute, regulation, rule, or order issued pursuant thereto, the relevant records may be disclosed to the appropriate Federal, foreign, State, local, tribal, or other public authority responsible for enforcing, investigating or prosecuting such violation or charged with enforcing or implementing the statute, rule, regulation, or order.
4. To any source or potential source from which information is requested in the course of an investigation concerning the hiring or retention of an employee or other personnel action, or the issuing or retention of a security clearance, contract, grant, license, or other benefit, to the extent necessary to identify the individual, inform the source of the nature and purpose of the investigation, and to identify the type of information requested.

5. To a Federal, State, local, foreign, tribal, or other public authority the fact that this system of records contains information relevant to the retention of an employee, or the retention of a security clearance, contract, license, grant, or other benefit. The other agency or licensing organization may then make a request supported by written consent of the individual for the entire record if it so chooses. No disclosure will be made unless the information has been determined to be sufficiently reliable to support a referral to another office within the agency or to another Federal agency for criminal, civil, administrative, personnel, or regulatory action.
6. To contractors, grantees, experts, consultants, or volunteers when necessary to perform a function or service related to this record for which they have been engaged. Such recipients shall be required to comply with the Privacy Act of 1974, as amended.
7. To the news media or the general public, factual information the disclosure of which would be in the public interest and which would not constitute an unwarranted invasion of personal privacy.
8. To a Federal, State, or local agency, or other appropriate entities or individuals, or through established liaison channels to selected foreign governments, in order to enable an intelligence agency to carry out its responsibilities under the National Security Act of 1947 as amended, the CIA Act of 1949 as amended, Executive Order 12333 or any successor order, applicable national security directives, or classified implementing procedures approved by the Attorney General and promulgated pursuant to such statutes, orders or directives.
9. To a Member of Congress or to a Congressional staff member in response to an inquiry of the Congressional office made at the written request of the constituent about whom the record is maintained.
10. To the National Archives and Records Administration for records management inspections conducted under 44 U.S.C. 2904 and 2906.
11. To the Office of Management and Budget when necessary to the review of private relief legislation.

LOCATION CODES

Alabama	AL	Hawaii	HI	Massachusetts	MA	New Mexico	NM	South Dakota	SD
Alaska	AK	Idaho	ID	Michigan	MI	New York	NY	Tennessee	TN
Arizona	AZ	Illinois	IL	Minnesota	MN	North Carolina	NC	Texas	TX
Arkansas	AR	Indiana	IN	Mississippi	MS	North Dakota	ND	Utah	UT
California	CA	Iowa	IA	Missouri	MO	Ohio	OH	Vermont	VT
Colorado	CO	Kansas	KS	Montana	MT	Oklahoma	OK	Virginia	VA
Connecticut	CT	Kentucky	KY	Nebraska	NE	Oregon	OR	Washington	WA
Delaware	DE	Louisiana	LA	Nevada	NV	Pennsylvania	PA	West Virginia	WV
District of Columbia	DC	Maine	ME	New Hampshire	NH	Rhode Island	RI	Wisconsin	WI
Florida	FL	Maryland	MD	New Jersey	NJ	South Carolina	SC	Wyoming	WY
Georgia	GA								
American Samoa	AS	Guam	GU	Northern Mariana Islands	MP	Palau	PW		
Federated States of Micronesia	FM	Marshall Islands	MH	Puerto Rico	PR	Virgin Islands of the U.S.	VI		

PUBLIC BURDEN INFORMATION

Public burden reporting for this collection of information is estimated to average 120 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 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.

**QUESTIONNAIRE FOR
 NATIONAL SECURITY POSITIONS**

Investigating agency use only	Codes	Case number
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AGENCY USE ONLY

A Type of investigation	B Extra coverage/Advance results	C Sensitivity level	D Access/Eligibility	E Nature of action code	F Date of action
G Geographic location	H Position code	I Position title			J SON
K Location of official personnel folder	<input type="checkbox"/> None <input type="checkbox"/> NPRC	<input type="checkbox"/> At SON <input type="checkbox"/> e-OPF	<input type="checkbox"/> Other	Other address/Web address of e-OPF	
L SOI	M Location of security folder	<input type="checkbox"/> None <input type="checkbox"/> NPI	<input type="checkbox"/> At SOI <input type="checkbox"/> Other	Other address	
N IPAC	O TAS	P Obligating document number		Q BETC	
R Accounting data and/or Agency case number				S Investigative requirement	<input type="checkbox"/> Initial <input type="checkbox"/> Reinvestigation
T Requesting official - Name		Title		Signature	
Email address			Telephone number	Date	
U Secondary requesting official - Name			Title		
Email address		Telephone number	V Applicant affiliation	<input type="checkbox"/> FED CIV <input type="checkbox"/> MIL	<input type="checkbox"/> CON <input type="checkbox"/> Other

PERSONS COMPLETING THIS FORM SHOULD BEGIN WITH THE QUESTIONS BELOW AFTER CAREFULLY READING THE FOREGOING INSTRUCTIONS.

1 FULL NAME - If you have only initials in your name, use them and enter (I/O) after the initial(s). - If you have no middle name, enter "NMN." - If you are a "Jr.," "Sr.," etc. enter this in the box after your middle name.	2 DATE OF BIRTH
--	-----------------

Last name Burke	First name Arleigh	Middle name Arnold	Jr., II, etc.
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3 PLACE OF BIRTH	4 SOCIAL SECURITY NO.			
City Boulder	County Boulder	State CO	Country (if outside the U.S.)	123-45-6789

5 OTHER NAMES USED Have you used any other names?
 NO YES -> If "Yes," give other names used and the period of time you used them [for example: your maiden name, name(s) by a former marriage, former name(s), alias(es), or nickname(s)]. If the other name is your maiden name, put "maiden" in front of it.

Name #1	Month/Year	To	Month/Year
Name #2	Month/Year	To	Month/Year
Name #3	Month/Year	To	Month/Year
Name #4	Month/Year	To	Month/Year

6 MOTHER'S MAIDEN NAME		
Last name Mokler	First name Clara	Middle name Faye

7 YOUR IDENTIFYING INFORMATION					
Height (feet and inches) 6' 0"	Weight (pounds) 160	Hair color Brown	Eye color Blue	Sex <input type="checkbox"/> Female <input checked="" type="checkbox"/> Male	

8 YOUR CONTACT INFORMATION Check box(es) indicating when you can be reached at each phone number.					
Home e-mail address arleighburke@gmail.com			Work e-mail address arleigh.burke@colorado.edu		
Home telephone number	<input type="checkbox"/>	Day	Work telephone number	<input type="checkbox"/>	Day
	<input type="checkbox"/>	Evening		<input type="checkbox"/>	Evening
			Mobile telephone number 303-123-4567	<input checked="" type="checkbox"/>	Day
				<input checked="" type="checkbox"/>	Evening

Enter your Social Security Number before going to the next page → 123-45-6789

QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

9 CITIZENSHIP Mark the box that reflects your current citizenship status and follow its instructions.									
<input checked="" type="checkbox"/> I am a U.S. citizen or national by birth in the U.S. or U.S. territory/commonwealth.					<input type="checkbox"/> I am a naturalized U.S. citizen. Go to 9B or 9C				
<input type="checkbox"/> I am a U.S. citizen or national by birth, born outside the U.S. Go to 9A					<input type="checkbox"/> I am not a U.S. citizen. Go to 9D				
U.S. PASSPORT <i>Current or most recent passport</i>					ALIEN REGISTRATION NUMBER <i>(if applicable)</i>				
Number 123456789		Date issued 08 AUG 2008		Expired <input checked="" type="checkbox"/>	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	Number		
9A DOCUMENTATION OF U.S. CITIZENS BORN ABROAD [STATE DEPARTMENT FORM (FS) 240, DS 1350, FS 545, etc.] <i>Report information, if applicable.</i>									
Date form was completed					Document number				
Date form was completed					Place of issuance				
9B CITIZENSHIP CERTIFICATE <i>(if applicable)</i>									
Where was this certificate issued? City/Court				State		Certificate number		Date issued	
9C NATURALIZATION CERTIFICATE <i>(if applicable)</i>									
Where was this certificate issued? City/Court				State		Certificate number		Date issued	
9D IMMIGRATION STATUS <i>Place you entered the U.S.</i>									
City			State		Country(ies) of citizenship				
Date of entry		Type of document (I-94, etc.)			Document number				
10 CITIZENSHIP INFORMATION									
Do you now hold or have you EVER held multiple citizenships?					YES <input checked="" type="checkbox"/> NO Go to Question 11				
A If "Yes," provide the name(s) of the country(ies).					B During what periods of time did you hold multiple citizenships?				
C Is your non-U.S. citizenship based on your birth in a foreign country or the citizenship of your parents? <i>(If "NO," explain.)</i>									
<input type="checkbox"/> YES <input type="checkbox"/> NO, explain →									
D Have you renounced or attempted to renounce your foreign citizenship(s)? <i>(If "Yes," explain.)</i>									
<input type="checkbox"/> NO <input type="checkbox"/> YES, explain →									
11 WHERE YOU HAVE LIVED Use the Continuation Sheet(s) (SF 86A) or the Continuation Space on page 17 for additional answers.									
List the places where you have lived, beginning with your present residence (#1) and working back 7 years (if an SSBI go back 10 years). Residences for the entire 7 year period must be accounted for without breaks. Indicate the actual physical location of your residence. Do not use a Post Office Box as an address, and do not list a permanent address when you were actually living at a school address, etc. Be sure to be as specific as possible when listing an address location: for example, do not list only your base or ship, list your barracks number or home port. You may omit temporary military duty locations (TDY) under 90 days (list your address of record instead), but you must list other part-time residences. Your actual physical location in addition to your APO/FPO address is required for overseas assignments.									
For any address in the last 3 years, list a person who knew you at that address, and who preferably still lives in that area. Do not list people for residences completely outside this 3-year period, and do not list your spouse, former spouse, or other relatives. Also, for addresses in the last 3 years, if the address is "General Delivery," a Rural or State Route, or may be difficult to locate, provide directions for locating the residence on an attached continuation sheet (SF 86A). Do not list residences before your 18th birthday unless to provide a minimum of 2 years of residence history.									
Residence Information and Point of Contact for that Period of Residence									
#1	Month/Year To	Month/Year	Status	Own	Military housing	Street address	Apt.#		
05/2007	Present			Rent	<input checked="" type="checkbox"/> Other <i>(Explain)</i>	123 Main St., Boulder, CO, 80303			
APO/FPO address									
City (Country)							State	ZIP Code	
Boulder (United States of America)							CO	80303	
Name of person who knows you at this address				Current address			Apt.#		
Robert Jones				130 Main St. Boulder, CO, 80303					
APO/FPO address <i>(if currently applicable)</i>									
City (Country)							State	ZIP Code	
Boulder (United States of America)							CO	80303	
Telephone number		Alternate contact number		Relationship		<input checked="" type="checkbox"/>	Neighbor	Landlord	Other <i>(Explain)</i>
303-213-1879						<input type="checkbox"/>	Friend	Business associate	

Enter your Social Security Number before going to the next page →

123-45-6789

QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

11 WHERE YOU HAVE LIVED (<i>Continued</i>)																				
#2	Month/Year	To	Month/Year	Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Own	<input type="checkbox"/>	<input type="checkbox"/>	Military housing	Street address	Apt.#							
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rent	<input type="checkbox"/>	<input type="checkbox"/>	Other (<i>Explain</i>)									
APO/FPO address																				
City (Country)												State	ZIP Code							
Name of person who knows you at this address												Current address		Apt.#						
APO/FPO address (<i>if currently applicable</i>)																				
City (Country)												State	ZIP Code							
Telephone number				Alternate contact number				Relationship		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neighbor	<input type="checkbox"/>	<input type="checkbox"/>	Landlord	<input type="checkbox"/>	<input type="checkbox"/>	Other (<i>Explain</i>)
										<input type="checkbox"/>	<input type="checkbox"/>	Friend	<input type="checkbox"/>	<input type="checkbox"/>	Business associate					
#3	Month/Year	To	Month/Year	Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Own	<input type="checkbox"/>	<input type="checkbox"/>	Military housing	Street address	Apt.#							
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rent	<input type="checkbox"/>	<input type="checkbox"/>	Other (<i>Explain</i>)									
APO/FPO address																				
City (Country)												State	ZIP Code							
Name of person who knows you at this address												Current address		Apt.#						
APO/FPO address (<i>if currently applicable</i>)																				
City (Country)												State	ZIP Code							
Telephone number				Alternate contact number				Relationship		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neighbor	<input type="checkbox"/>	<input type="checkbox"/>	Landlord	<input type="checkbox"/>	<input type="checkbox"/>	Other (<i>Explain</i>)
										<input type="checkbox"/>	<input type="checkbox"/>	Friend	<input type="checkbox"/>	<input type="checkbox"/>	Business associate					
#4	Month/Year	To	Month/Year	Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Own	<input type="checkbox"/>	<input type="checkbox"/>	Military housing	Street address	Apt.#							
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rent	<input type="checkbox"/>	<input type="checkbox"/>	Other (<i>Explain</i>)									
APO/FPO address																				
City (Country)												State	ZIP Code							
Name of person who knows you at this address												Current address		Apt.#						
APO/FPO address (<i>if currently applicable</i>)																				
City (Country)												State	ZIP Code							
Telephone number				Alternate contact number				Relationship		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neighbor	<input type="checkbox"/>	<input type="checkbox"/>	Landlord	<input type="checkbox"/>	<input type="checkbox"/>	Other (<i>Explain</i>)
										<input type="checkbox"/>	<input type="checkbox"/>	Friend	<input type="checkbox"/>	<input type="checkbox"/>	Business associate					

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QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

12 WHERE YOU WENT TO SCHOOL Use the Continuation Sheet(s) (SF 86A) or the Continuation Space on page 17 for additional answers.

List all schools you have attended, beginning with the most recent (#1) working back 7 years (if an SSBI go back 10 years). List college or university degrees and the dates they were received. If your most recent degree or diploma was received more than 7 years ago (10 years for an SSBI), list it below no matter when it was received.

In the Code block, show the most appropriate code to describe your school.

- | | |
|---|---|
| 1 - High School | 3 - Vocational/Technical/Trade School |
| 2 - College/University/Military College | 4 - Correspondence/Distance/Extension/Online School |

For Correspondence/Distance/Extension/Online School, provide the address where the records are maintained.

For schools you attended in the last 3 years, list a person who knew you at school (instructor, student, etc.).

Do not list people for education periods completed more than 3 years ago.

SCHOOL INFORMATION

#1	Month/Year	To	Month/Year	Code	Name of school	Degree/diploma received? If "Yes," identify type of degree/diploma received and date awarded.	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
	08/2012		05/2016	1	Boulder High School		

Street address and City (Country) of school	State	ZIP Code
1604 Arapahoe Ave., Boulder (United States of America)	CO	80302

Name of person who knows you	Current address	Apt. #
Michael Smith	1500 Broadway Ave.	

City (Country)	State	ZIP Code	Telephone number
Boulder	CO	80309	303-256-1121

#2	Month/Year	To	Month/Year	Code	Name of school	Degree/diploma received? If "Yes," identify type of degree/diploma received and date awarded.	<input type="checkbox"/> YES <input type="checkbox"/> NO

Street address and City (Country) of school	State	ZIP Code

Name of person who knows you	Current address	Apt. #

City (Country)	State	ZIP Code	Telephone number

#3	Month/Year	To	Month/Year	Code	Name of school	Degree/diploma received? If "Yes," identify type of degree/diploma received and date awarded.	<input type="checkbox"/> YES <input type="checkbox"/> NO

Street address and City (Country) of school	State	ZIP Code

Name of person who knows you	Current address	Apt. #

City (Country)	State	ZIP Code	Telephone number

#4	Month/Year	To	Month/Year	Code	Name of school	Degree/diploma received? If "Yes," identify type of degree/diploma received and date awarded.	<input type="checkbox"/> YES <input type="checkbox"/> NO

Street address and City (Country) of school	State	ZIP Code

Name of person who knows you	Current address	Apt. #

City (Country)	State	ZIP Code	Telephone number

#5	Month/Year	To	Month/Year	Code	Name of school	Degree/diploma received? If "Yes," identify type of degree/diploma received and date awarded.	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

Street address and City (Country) of school	State	ZIP Code

Name of person who knows you	Current address	Apt. #

City (Country)	State	ZIP Code	Telephone number

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QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

13 EMPLOYMENT ACTIVITIES Use the Continuation Sheet(s) (SF 86A) or the Continuation Space on page 17 for additional answers.

List all your employment activities, beginning with the present (#1) and working back 7 years (if an SSBI go back 10 years). You should list all full-time and part-time work, paid or unpaid, consulting/contracting work, all military service duty locations, temporary military duty locations (TDY) over 90 days, self-employment, other paid work, and all periods of unemployment. **The entire period must be accounted for without breaks.** EXCEPTION: Do not list employments that occurred before your 18th birthday unless it is necessary for providing a minimum of 2 years of employment history. If you require additional space, use a continuation sheet (SF 86A).

Employer/Verifier Information. List the business name of your employer or the name of a person who can verify your self-employment or unemployment in this block. If military service is being listed, include your duty location or home port here as well as your branch of service. You should provide separate listings to reflect changes in your military duty locations or home ports. If you are a Federal Contractor, list company name, not Federal agency.

Additional Periods of Activity. Complete this block if you worked for an employer on more than one occasion at the same physical location. After entering the most recent period of employment in the initial numbered block, provide previous periods of employment at the same location on the additional lines provided. For example, if you worked at XY Plumbing in Denver, CO, during 3 separate periods of time, you would enter dates and information concerning the most recent period of employment first, and provide dates, position titles, and supervisors for the two previous periods of employment on the lines below that information.

Employment Code: Use one of the codes listed below to identify the type of employment.

- | | | |
|-----------------------------------|--|---|
| 1 - Active military duty stations | 4 - Other Federal employment | 7 - Unemployment (include name of verifier) |
| 2 - National Guard/Reserve | 5 - State Government (Non-Federal employment) | 8 - Federal Contractor |
| 3 - U.S.P.H.S. Commissioned Corps | 6 - Self-employment (include business name and/or name of person who can verify) | 9 - Other (explain) |

13A EMPLOYMENT/UNEMPLOYMENT INFORMATION

#1 Dates of Employment		Type of Employment		Work hours	Full-time	
Month/Year	To Month/Year	Employment code	Position title/Military rank		Part-time	
06/2013	Present	9	Server			x
Employer/Verifier						
Name of employer/verifier Chipotle					Telephone number 303-244-7653	
Address of employer/verifier 1650 28th St.						
City (Country) Boulder (United States of America)					State CO	ZIP Code 80302
Physical Location						
Your actual work address (if different from employer address)					Telephone number	
City (Country)					State	ZIP Code
Supervisor (if different from employer)						
Name and title Steve Ells					Telephone number 303-244-7653	
Work address of supervisor 1650 28th St.						
City (Country) Boulder (University of Colorado)					State CO	ZIP Code 80302
Additional Periods of Activity with this Employer						
Month/Year	To	Month/Year	Position title	Supervisor		
Month/Year	To	Month/Year	Position title	Supervisor		
Month/Year	To	Month/Year	Position title	Supervisor		
Explanation/Reason for leaving						

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**QUESTIONNAIRE FOR
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13A EMPLOYMENT/UNEMPLOYMENT INFORMATION (Continued)									
#2 Dates of Employment				Type of Employment					
Month/Year	To	Month/Year		Employment code	Position title/Military rank		Work hours	Full-time	
								Part-time	
Employer/Verifier									
Name of employer/verifier							Telephone number		
Address of employer/verifier									
City (Country)							State	ZIP Code	
Physical Location									
Your actual work address (if different from employer address)							Telephone number		
City (Country)							State	ZIP Code	
Supervisor (if different from employer)									
Name and title							Telephone number		
Work address of supervisor									
City (Country)							State	ZIP Code	
Additional Periods of Activity with this Employer									
Month/Year	To	Month/Year		Position title	Supervisor				
Month/Year	To	Month/Year		Position title	Supervisor				
Month/Year	To	Month/Year		Position title	Supervisor				
Explanation/Reason for leaving									
#3 Dates of Employment									
#3 Dates of Employment				Type of Employment					
Month/Year	To	Month/Year		Employment code	Position title/Military rank		Work hours	Full-time	
								Part-time	
Employer/Verifier									
Name of employer/verifier							Telephone number		
Address of employer/verifier									
City (Country)							State	ZIP Code	
Physical Location									
Your actual work address (if different from employer address)							Telephone number		
City (Country)							State	ZIP Code	

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**QUESTIONNAIRE FOR
 NATIONAL SECURITY POSITIONS**

13A EMPLOYMENT/UNEMPLOYMENT INFORMATION (Continued)									
Supervisor (if different from employer)									
Name and title							Telephone number		
Work address of supervisor									
City (Country)							State	ZIP Code	
Additional Periods of Activity with this Employer									
Month/Year	To	Month/Year	Position title				Supervisor		
Month/Year	To	Month/Year	Position title				Supervisor		
Month/Year	To	Month/Year	Position title				Supervisor		
Explanation/Reason for leaving									
#4 Dates of Employment		Type of Employment							
Month/Year	To	Month/Year	Employment code		Position title/Military rank			Work hours	Full-time Part-time
Employer/Verifier									
Name of employer/verifier							Telephone number		
Address of employer/verifier									
City (Country)							State	ZIP Code	
Physical Location									
Your actual work address (if different from employer address)							Telephone number		
City (Country)							State	ZIP Code	
Supervisor (if different from employer)									
Name and title							Telephone number		
Work address of supervisor									
City (Country)							State	ZIP Code	
Additional Periods of Activity with this Employer									
Month/Year	To	Month/Year	Position title				Supervisor		
Month/Year	To	Month/Year	Position title				Supervisor		
Month/Year	To	Month/Year	Position title				Supervisor		
Explanation/Reason for leaving									

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QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

13B FORMER FEDERAL SERVICE, EXCLUDING MILITARY SERVICE, <u>NOT</u> INDICATED PREVIOUSLY (list below if applicable)							
Dates of Federal Service Month/Year To Month/Year	Agency/City (Country)/State/ZIP Code				Position Title		
#1							
#2							
#3							
13C EMPLOYMENT RECORD						YES	NO
1. Has any of the following happened to you in the last 7 years? If "Yes," begin with the most recent occurrence and go backward, providing date fired, quit, or left, and other information requested.						<input type="checkbox"/>	<input checked="" type="checkbox"/>
Use the following codes and explain the reason your employment was ended. 1 - Fired from a job 3 - Left a job by mutual agreement following charges or allegations of misconduct 5 - Left a job for other reasons under unfavorable circumstances 2 - Quit a job after being told you would be fired 4 - Left a job by mutual agreement following notice of unsatisfactory performance 6 - Laid off from job by employer							
Month/Year	Code	Specify Reason	Employer's Name and Address (Include City/Country if outside U.S.)		State	ZIP Code	
						YES	NO
2. Have you received a written warning, been officially reprimanded, suspended, or disciplined for misconduct in the workplace?						<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Have you received a written warning, been officially reprimanded, suspended, or disciplined for violating a security rule or policy?						<input type="checkbox"/>	<input checked="" type="checkbox"/>
If you answered "Yes," to 13C(2) and/or 13C(3), provide the name(s) of the employer(s), date(s) of incident(s), month/day/year of official action(s), location(s) or facility(ies) of incident(s), and the nature of the violation(s) in the space below. If additional space is needed, use a blank sheet(s) of paper.							
14 SELECTIVE SERVICE RECORD						YES	NO
a Are you a male born after December 31, 1959? If "No," go to Question 15. If "Yes," go to b.						<input checked="" type="checkbox"/>	<input type="checkbox"/>
b Have you registered with the Selective Service System (SSS)? If "Yes," provide your registration number below. If "No," explain the reason for not registering below. Please consult the SSS if you are unaware of your status before signing this form.						<input checked="" type="checkbox"/>	<input type="checkbox"/>
Registration Number	Explanation						
12-1234567-1	Note: You can register as early as 17 yrs 3 months old.						

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QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

15 MILITARY HISTORY Account for all of your military service through the questions below. If you answer "No" to both 15a and 15b, go to Question 16.	YES	NO
a Have you EVER served in the U.S. military or the U.S. Merchant Marine?		X
b Have you EVER served in a foreign country's military, security forces, merchant marine, militia, or other defense forces?		X
c Have you EVER received a discharge that was not honorable?		X
d In the last 7 years (if an SSBI go back 10 years), have you been subject to court martial or other disciplinary proceedings under the Uniform Code of Military Justice? (Include non-judicial, Captain's mast, etc.) If "Yes," provide date(s), charge(s), military court(s) or authority(ies), and outcome(s).		X

If you answered "Yes" to any question above, list all details of your military service below, starting with the most recent period of service and working back. If you had a break in service, each separate time of service should be listed.

Code (Branch of Service): Use one of the codes listed below to identify your branch of service.

- 1 - Air Force 3 - Navy 5 - Coast Guard 7 - Air National Guard (NG) 9 - Foreign military, defense, militia, security forces
 2 - Army 4 - Marine Corps 6 - Merchant Marine 8 - Army NG

O/E: Mark "O" block for Officer or "E" block for Enlisted, if applicable.

Status: "X" the appropriate block for the status of your service during the time that you served. If your service was in the National Guard, do not use an "X"; use the two-letter code for the state to mark the block.

Country: Identify the country for which you served.

Code (Type of Discharge): Use one of the codes listed below to indicate your separation status from your military service.

- 1 - Honorable 2 - Dishonorable 3 - Other Than Honorable 4 - General 5 - Bad Conduct 6 - Other (Explain)

Branch of Service Code	Month/Year To Month/Year	Service Number	O	E	Status					Country	Type of Discharge Code
					Active Duty	Active Reserve	Inactive Reserve	Air NG State	Army NG State		

16 PEOPLE WHO KNOW YOU WELL

List three people who know you well and who preferably live in the U. S. They should be friends, peers, colleagues, college roommates, associates, etc., who are collectively aware of your activities outside of the workplace, school, or neighborhoods and whose combined association with you covers at least the last 7 years. **Do not list your spouse, former spouse(s), other relatives, or anyone listed elsewhere on this form.**

Reference name #1 George Washington	Dates known Month/Year To Month/Year 03/2006 Present	Relationship to you (Check all that apply) <input type="checkbox"/> Neighbor <input type="checkbox"/> Work associate <input type="checkbox"/> Other (Explain) <input checked="" type="checkbox"/> Friend <input type="checkbox"/> Schoolmate	Telephone number 619-242-1345 <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Evening
Home or work address 3200 Mount Vernon Hwy	Apt. #	City (Country) Mt. Vernon	State ZIP Code VA 22121
Alternate telephone no.			
Reference name #2 Barack Obama	Dates known Month/Year To Month/Year 02/2002 Present	Relationship to you (Check all that apply) <input type="checkbox"/> Neighbor <input checked="" type="checkbox"/> Work associate <input type="checkbox"/> Other (Explain) <input type="checkbox"/> Friend <input type="checkbox"/> Schoolmate	Telephone number 525-25-1234 <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Evening
Home or work address 1600 Pennsylvania Ave.	Apt. #	City (Country) Washington	State ZIP Code DC 20500
Alternate telephone no.			
Reference name #3 Thomas Jefferson	Dates known Month/Year To Month/Year 08/2010 Present	Relationship to you (Check all that apply) <input type="checkbox"/> Neighbor <input type="checkbox"/> Work associate <input type="checkbox"/> Other (Explain) <input type="checkbox"/> Friend <input checked="" type="checkbox"/> Schoolmate	Telephone number 457-89-1652 <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Evening
Home or work address 931 Thomas Jefferson Pkwy	Apt. #	City (Country) Charlottesville	State ZIP Code VA 22902
Alternate telephone no.			

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QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

17 MARITAL STATUS										
Mark one box to show your current marital status and provide information about your spouse(s) or cohabitant below. If there is not a middle name, enter as "NMN."										
<input checked="" type="checkbox"/>	1 - Never married		<input type="checkbox"/>	3 - Separated		<input type="checkbox"/>	5 - Divorced			
<input type="checkbox"/>	2 - Married (incl. Common Law)		<input type="checkbox"/>	4 - Annulled		<input type="checkbox"/>	6 - Widowed			
17A CURRENT SPOUSE If applicable, complete the following about your current spouse only. If your current spouse was born outside the U.S., provide citizenship information.										
Last name		First name		Middle name		Date of birth		Place of birth (include Country if outside the U.S.)		
Social Security Number		Other names used (specify maiden name, names by other marriages, etc., and show dates used for each name)								
Country(ies) of citizenship								Date married		
Place married (City, include Country if outside the U.S.)								State		
If separated, date of separation				If legally separated, where is the record located? City (Country)				State	ZIP Code	
Current address of spouse, if different than your current address (Street, City, include Country if outside the U.S.)						State	ZIP Code	Telephone number		
If spouse was born outside the U.S. indicate one type of documentation that he or she possesses and the document numbers.										
<input type="checkbox"/>	FS 240 or 545		<input type="checkbox"/>	Citizenship certificate		<input type="checkbox"/>	Alien registration		<input type="checkbox"/>	Other (Explain)
<input type="checkbox"/>	DS 1350		<input type="checkbox"/>	U.S. Passport (current or most recent)		<input type="checkbox"/>	Naturalization certificate			
Document number						Explain "Other"				
17B FORMER SPOUSE(S) Complete the following about your former spouse(s). Use blank sheets if needed.										
Last name		First name		Middle name		Date of birth				
Place of birth (include Country if outside the U.S.)				State	Country(ies) of citizenship					
Date married		Place married (City, include Country if outside the U.S.)						State		
Check one, then give date	<input type="checkbox"/>	Divorced	<input type="checkbox"/>	Annulled	Date	If divorced/annulled, where is the record located? City (Country)		State	ZIP Code	
	<input type="checkbox"/>	Widowed								
Last known address of former spouse (Street, City, include Country if outside the U.S.)						State	ZIP Code	Telephone number		
17C COHABITANT [A cohabitant is a person with whom you share bonds of affection, obligation, or other commitment, as opposed to a person with whom you live for reasons of convenience (a roommate)]. If applicable, complete the following about your cohabitant. If your cohabitant was born outside the U.S., provide citizenship information.										
Last name		First name		Middle name		Date of birth		Place of birth (include Country if outside the U.S.)		
Social Security Number		Other names used (specifically maiden names, names by other marriages, etc., and show dates used for each name)								
Country(ies) of citizenship								Date cohabitation began		
If cohabitant was born outside the U.S., indicate one type of documentation that he or she possesses and the document numbers.										
<input type="checkbox"/>	FS 240 or 545		<input type="checkbox"/>	Citizenship certificate		<input type="checkbox"/>	Alien registration		<input type="checkbox"/>	Other (Explain)
<input type="checkbox"/>	DS 1350		<input type="checkbox"/>	U.S. Passport (current or most recent)		<input type="checkbox"/>	Naturalization certificate			
Document number						Explain "Other"				

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QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

18 RELATIVES					
Relative Code - Use one of the following codes (1-16) listed below for each relative and give the full name and other requested information, if applicable, for each of your relatives, living or deceased, specified below.					
1 - Mother		5 - Foster parent		9 - Sister	
2 - Father		6 - Child (<i>incl. adopted and foster</i>)		10 - Stepbrother	
3 - Stepmother		7 - Stepchild		11 - Stepsister	
4 - Stepfather		8 - Brother		12 - Half-brother	
				13 - Half-sister	
				14 - Father-in-law	
				15 - Mother-in-law	
				16 - Guardian	
Code 1	Full name Clara Faye Burke	<input type="checkbox"/> Deceased	Date of birth 1/1/75	Place of birth San Francisco, CA	Country(ies) of citizenship United States of America
Current address (<i>Street, City, and State, include Country if outside the U.S.</i>) 123 Main St., Boulder, CO					
If relative was born outside the U.S., indicate one type of documentation that he or she possesses and provide the document number below.					
<input type="checkbox"/> FS 240 or 545		<input type="checkbox"/> DS 1350		<input type="checkbox"/> Alien registration	
<input type="checkbox"/> Citizenship certificate		<input type="checkbox"/> Naturalization certificate		<input type="checkbox"/> U.S. Passport	
				<input type="checkbox"/> Other (Explain below)	
Document number					
Code 2	Full name Oscar Brandon Burke	<input type="checkbox"/> Deceased	Date of birth 3/17/72	Place of birth San Diego, CA	Country(ies) of citizenship United States of America
Current address (<i>Street, City, and State, include Country if outside the U.S.</i>) 123 Main St. Boulder, CO					
If relative was born outside the U.S., indicate one type of documentation that he or she possesses and provide the document number below.					
<input type="checkbox"/> FS 240 or 545		<input type="checkbox"/> DS 1350		<input type="checkbox"/> Alien registration	
<input type="checkbox"/> Citizenship certificate		<input type="checkbox"/> Naturalization certificate		<input type="checkbox"/> U.S. Passport	
				<input type="checkbox"/> Other (Explain below)	
Document number					
Code 8	Full name Ronald James Burke	<input type="checkbox"/> Deceased	Date of birth 6/15/04	Place of birth Boulder, CO	Country(ies) of citizenship United States of America
Current address (<i>Street, City, and State, include Country if outside the U.S.</i>) 123 Main St. Boulder, CO					
If relative was born outside the U.S., indicate one type of documentation that he or she possesses and provide the document number below.					
<input type="checkbox"/> FS 240 or 545		<input type="checkbox"/> DS 1350		<input type="checkbox"/> Alien registration	
<input type="checkbox"/> Citizenship certificate		<input type="checkbox"/> Naturalization certificate		<input type="checkbox"/> U.S. Passport	
				<input type="checkbox"/> Other (Explain below)	
Document number					
Code	Full name	<input type="checkbox"/> Deceased	Date of birth	Place of birth	Country(ies) of citizenship
Current address (<i>Street, City, and State, include Country if outside the U.S.</i>)					
If relative was born outside the U.S., indicate one type of documentation that he or she possesses and provide the document number below.					
<input type="checkbox"/> FS 240 or 545		<input type="checkbox"/> DS 1350		<input type="checkbox"/> Alien registration	
<input type="checkbox"/> Citizenship certificate		<input type="checkbox"/> Naturalization certificate		<input type="checkbox"/> U.S. Passport	
				<input type="checkbox"/> Other (Explain below)	
Document number					
Code	Full name	<input type="checkbox"/> Deceased	Date of birth	Place of birth	Country(ies) of citizenship
Current address (<i>Street, City, and State, include Country if outside the U.S.</i>)					
If relative was born outside the U.S., indicate one type of documentation that he or she possesses and provide the document number below.					
<input type="checkbox"/> FS 240 or 545		<input type="checkbox"/> DS 1350		<input type="checkbox"/> Alien registration	
<input type="checkbox"/> Citizenship certificate		<input type="checkbox"/> Naturalization certificate		<input type="checkbox"/> U.S. Passport	
				<input type="checkbox"/> Other (Explain below)	
Document number					
Code	Full name	<input type="checkbox"/> Deceased	Date of birth	Place of birth	Country(ies) of citizenship
Current address (<i>Street, City, and State, include Country if outside the U.S.</i>)					
If relative was born outside the U.S., indicate one type of documentation that he or she possesses and provide the document number below.					
<input type="checkbox"/> FS 240 or 545		<input type="checkbox"/> DS 1350		<input type="checkbox"/> Alien registration	
<input type="checkbox"/> Citizenship certificate		<input type="checkbox"/> Naturalization certificate		<input type="checkbox"/> U.S. Passport	
				<input type="checkbox"/> Other (Explain below)	
Document number					
Code	Full name	<input type="checkbox"/> Deceased	Date of birth	Place of birth	Country(ies) of citizenship
Current address (<i>Street, City, and State, include Country if outside the U.S.</i>)					
If relative was born outside the U.S., indicate one type of documentation that he or she possesses and provide the document number below.					
<input type="checkbox"/> FS 240 or 545		<input type="checkbox"/> DS 1350		<input type="checkbox"/> Alien registration	
<input type="checkbox"/> Citizenship certificate		<input type="checkbox"/> Naturalization certificate		<input type="checkbox"/> U.S. Passport	
				<input type="checkbox"/> Other (Explain below)	
Document number					
Code	Full name	<input type="checkbox"/> Deceased	Date of birth	Place of birth	Country(ies) of citizenship
Current address (<i>Street, City, and State, include Country if outside the U.S.</i>)					
If relative was born outside the U.S., indicate one type of documentation that he or she possesses and provide the document number below.					
<input type="checkbox"/> FS 240 or 545		<input type="checkbox"/> DS 1350		<input type="checkbox"/> Alien registration	
<input type="checkbox"/> Citizenship certificate		<input type="checkbox"/> Naturalization certificate		<input type="checkbox"/> U.S. Passport	
				<input type="checkbox"/> Other (Explain below)	
Document number					

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**QUESTIONNAIRE FOR
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19 FOREIGN CONTACTS

Do you have or have you had close and/or continuing contact with foreign nationals within the last 7 years with whom you, your spouse, or your cohabitant are bound by affection, influence, and/or obligation? Include associates, as well as relatives, not already listed in Question 18. (A foreign national is defined as any person who is not a citizen or national of the U.S.) Yes No

1. Full name Winston Leonard Churchill	Dates known Month/Year To Month/Year	Country(ies) of citizenship England
	2/13/02 Present	Country of residence England
Nature of relationship <input type="checkbox"/> Business <input checked="" type="checkbox"/> Personal <input type="checkbox"/> Other (Explain)	Type of contact (check all that apply) <input checked="" type="checkbox"/> Telephone <input checked="" type="checkbox"/> Electronic correspondence <input type="checkbox"/> Other (Explain) <input checked="" type="checkbox"/> In person <input type="checkbox"/> Written correspondence	Number of contacts per year <input type="checkbox"/> 1 - 2 <input checked="" type="checkbox"/> 3 - 7 <input type="checkbox"/> 8 - 15 <input type="checkbox"/> More than 15
2. Full name	Dates known Month/Year To Month/Year	Country(ies) of citizenship
		Country of residence
Nature of relationship <input type="checkbox"/> Business <input type="checkbox"/> Personal <input type="checkbox"/> Other (Explain)	Type of contact (check all that apply) <input type="checkbox"/> Telephone <input type="checkbox"/> Electronic correspondence <input type="checkbox"/> Other (Explain) <input type="checkbox"/> In person <input type="checkbox"/> Written correspondence	Number of contacts per year <input type="checkbox"/> 1 - 2 <input type="checkbox"/> 3 - 7 <input type="checkbox"/> 8 - 15 <input type="checkbox"/> More than 15
3. Full name	Dates known Month/Year To Month/Year	Country(ies) of citizenship
		Country of residence
Nature of relationship <input type="checkbox"/> Business <input type="checkbox"/> Personal <input type="checkbox"/> Other (Explain)	Type of contact (check all that apply) <input type="checkbox"/> Telephone <input type="checkbox"/> Electronic correspondence <input type="checkbox"/> Other (Explain) <input type="checkbox"/> In person <input type="checkbox"/> Written correspondence	Number of contacts per year <input type="checkbox"/> 1 - 2 <input type="checkbox"/> 3 - 7 <input type="checkbox"/> 8 - 15 <input type="checkbox"/> More than 15
4. Full name	Dates known Month/Year To Month/Year	Country(ies) of citizenship
		Country of residence
Nature of relationship <input type="checkbox"/> Business <input type="checkbox"/> Personal <input type="checkbox"/> Other (Explain)	Type of contact (check all that apply) <input type="checkbox"/> Telephone <input type="checkbox"/> Electronic correspondence <input type="checkbox"/> Other (Explain) <input type="checkbox"/> In person <input type="checkbox"/> Written correspondence	Number of contacts per year <input type="checkbox"/> 1 - 2 <input type="checkbox"/> 3 - 7 <input type="checkbox"/> 8 - 15 <input type="checkbox"/> More than 15
5. Full name	Dates known Month/Year To Month/Year	Country(ies) of citizenship
		Country of residence
Nature of relationship <input type="checkbox"/> Business <input type="checkbox"/> Personal <input type="checkbox"/> Other (Explain)	Type of contact (check all that apply) <input type="checkbox"/> Telephone <input type="checkbox"/> Electronic correspondence <input type="checkbox"/> Other (Explain) <input type="checkbox"/> In person <input type="checkbox"/> Written correspondence	Number of contacts per year <input type="checkbox"/> 1 - 2 <input type="checkbox"/> 3 - 7 <input type="checkbox"/> 8 - 15 <input type="checkbox"/> More than 15
6. Full name	Dates known Month/Year To Month/Year	Country(ies) of citizenship
		Country of residence
Nature of relationship <input type="checkbox"/> Business <input type="checkbox"/> Personal <input type="checkbox"/> Other (Explain)	Type of contact (check all that apply) <input type="checkbox"/> Telephone <input type="checkbox"/> Electronic correspondence <input type="checkbox"/> Other (Explain) <input type="checkbox"/> In person <input type="checkbox"/> Written correspondence	Number of contacts per year <input type="checkbox"/> 1 - 2 <input type="checkbox"/> 3 - 7 <input type="checkbox"/> 8 - 15 <input type="checkbox"/> More than 15

20 FOREIGN ACTIVITIES Respond for the time frame of the last 7 years.

20A Foreign Financial Interests Include stocks, personal property, company shares, investments, or ownership of corporate entities. Exclude U.S.-based fund managers and accounts managed through your employer.		YES	NO
1. Do you have or have you EVER had any foreign financial businesses, foreign bank accounts, or other foreign financial interests of which you have direct control or direct ownership?			X
Type of financial interest	Amount of funds in U.S. dollars		
2. Do you have or have you had any foreign financial interests that someone controls on your behalf?			X
Type of financial interest and name of party who controls it	Amount of funds in U.S. dollars		
3. Do you own or have you owned real estate in a foreign country?			X
Type of property and date(s) owned	Location of property	Estimated value of property in U.S. dollars	
4. Do you receive or have you received any educational, medical, retirement, social welfare, or other such benefits from a foreign country?			X
Type of benefit	Estimated value in U.S. dollars		

Enter your Social Security Number before going to the next page

QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

20B Foreign Business, Professional Activities, and Foreign Government Contacts Respond for the time frame of the last 7 years, unless otherwise noted. Indicate if activity was on official U.S. Government business.	YES	NO	Official Govt. Business
1. Have you provided advice or support to anyone associated with a foreign business or other foreign organization that you have not previously listed as a former employer regarding any of the following: management, strategy, financing, or technology?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
If "Yes" AND the activity was outside of official U.S. Government business, describe advice/support provided, name(s) of foreign national and/or organization(s) to which it was provided, the name(s) of foreign country(ies), timeframe(s), and if compensation was provided.			
2. Have you attended any international conferences, trade shows, seminars, or other meetings outside of the U.S.?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
If "Yes" AND the activity was outside of official U.S. Government business, provide locations, including the name(s) of foreign country(ies), date(s), sponsoring organization(s), and purpose of event(s).			
3. Have you or any of your immediate family members been asked to provide advice or serve as a consultant, even informally, by any foreign government official or agency?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
If "Yes" AND the activity was outside of official U.S. Government business, provide the date(s) of request and/or consultation(s), including the name(s) of foreign country(ies), location of consultation(s), and circumstance(s).			
4. Have you or any of your immediate family members had any contact with a foreign government, its establishment (embassies, consulates, agencies, or military services), or its representatives, whether inside or outside the U.S.?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Answer "No" if the contact was for routine visa applications and border crossings related to either official U.S. Government travel or foreign travel listed below in Question 20C. If contact was outside of official U.S. Government business, identify the foreign government(s), establishment(s), and/or representative(s) involved and provide the circumstance(s), date(s), and location(s) of contact(s).			
5. Have you sponsored any foreign citizen to come to the U.S. as a student, for work, or for permanent residence?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
If "Yes," provide the name of the foreign citizen(s) you sponsored, the country(ies) of citizenship, the date(s) of the foreign citizen's stay in the U.S., their current address (if known), and the purpose of the foreign citizen's stay in the U.S.			
6. Have you EVER held or do you now hold a passport that was issued by a foreign government?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
If "Yes," provide the name(s), in which your foreign passport(s) was issued, the issuing country(ies), the passport number(s), the date(s) issued, the expiration date(s), and the status of each.			

20C Foreign Countries You Have Visited Respond for the time frame of the last 7 years.	YES	NO							
Have you traveled outside the U.S. in the last 7 years?	<input checked="" type="checkbox"/>	<input type="checkbox"/>							
Respond for foreign countries you have visited in the last 7 years, beginning with the most current and working back. If you have lived near a border and have made short (one day or less) trips to the neighboring country (e.g. Canada or Mexico), you do not need to list each trip. Instead, provide the time period, the code, the country, and a note ("Many Short Trips"). Do not list travel under official U.S. Government business, but you must include any personal trips made in conjunction with the official U.S. Government travel.									
Use these codes to indicate the purpose(s) of your visit: 1 - Business/Professional conference 3 - Education 5 - Visit family or friends 2 - Volunteer activities 4 - Tourism 6 - Other									
Code	Month/Year To	Month/Year	Number of Days	Country	Code	Month/Year To	Month/Year	Number of Days	Country
4	#1	06/2012 - 06/2012	7	Spain	#4				
4	#2	7/2013-7/2013	9	England	#5				
4	#3	8/2014-9/2014	5	Mexico	#6				

21 MENTAL AND EMOTIONAL HEALTH					
Mental health counseling in and of itself is not a reason to revoke or deny a clearance.			YES	NO	
In the last 7 years, have you consulted with a health care professional regarding an emotional or mental health condition or were you hospitalized for such a condition? Answer "No" if the counseling was for any of the following reasons and was not court-ordered: 1) strictly marital, family, grief not related to violence by you; or 2) strictly related to adjustments from service in a military combat environment.			<input type="checkbox"/>	<input checked="" type="checkbox"/>	
If you answered "Yes," indicate who conducted the treatment and/or counseling, provide the following information, and sign the <i>Authorization for Release of Medical Information Pursuant to the Health Insurance Portability and Accountability Act (HIPAA)</i> .					
Dates of Treatment and/or Counseling Month/Year To Month/Year	Name/Address of Provider			State	ZIP Code
#1					
#2					

Enter your Social Security Number before going to the next page → 123-45-6789

QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

22 POLICE RECORD

For this item, report information regardless of whether the record in your case has been sealed, expunged, or otherwise stricken from the court record, or the charge was dismissed. You need not report convictions under the Federal Controlled Substances Act for which the court issued an expungement order under the authority of 21 U.S.C. 844 or 18 U.S.C. 3607. Be sure to include all incidents whether occurring in the U.S. or abroad.

For questions a and b, respond for the timeframe of the last 7 years (if an SSBI go back 10 years). Exclude any fines of less than \$300 for traffic offenses that do not involve alcohol or drugs.	YES	NO
a. Have you been issued a summons, citation, or ticket to appear in court in a criminal proceeding against you; are you on trial or awaiting a trial on criminal charges; or are you currently awaiting sentencing for a criminal offense?		X
b. Have you been arrested by any police officer, sheriff, marshal, or any other type of law enforcement officer?		X
c. Have you EVER been charged with any felony offense? (Include those under Uniform Code of Military Justice.)		X
d. Have you EVER been charged with a firearms or explosives offense?		X
e. Have you EVER been charged with any offense(s) related to alcohol or drugs?		X

If you answered "Yes" to any question above, explain below, providing information for each and every offense.

Month/Year	Law Enforcement Authority/Court	City and Country (if outside U.S.)	State	ZIP Code	Offense	Action Taken
#1						
#2						

23 ILLEGAL USE OF DRUGS OR 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)? Use of a controlled substance includes injecting, snorting, inhaling, swallowing, experimenting with or otherwise consuming any controlled substance.		X
b. Have you EVER illegally used a controlled substance while possessing a security clearance; while employed as a law enforcement officer, prosecutor, or courtroom official; or while in a position directly and immediately affecting the public safety?		X
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?		X
d. 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 drugs? If you answered "Yes," provide date(s) of treatment and name(s) and address(es) of provider(s). You will be asked to sign an additional release if information is needed concerning any treatment.		X

If you answered "Yes" to a - d above, 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		

24 USE OF ALCOHOL Respond for the time frame of the last 7 years.

	YES	NO
a. Has your use of alcohol had a negative impact on your work performance, your professional or personal relationships, your finances, or resulted in intervention by law enforcement/public safety personnel? (If "Yes," explain.)		X
b. Have you been ordered, advised, or asked to seek counseling or treatment as a result of your use of alcohol?		X
c. Have you received counseling or treatment as a result of your use of alcohol?		X

If you answered "Yes" to question b or c above, provide the date(s) of treatment and the name(s) and address(es) of the counselor(s) or doctor(s) below. Do not repeat information reported in response to Question 21. You will be asked to sign an additional release if information is needed concerning any treatment.

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

Enter your Social Security Number before going to the next page

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QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

25 INVESTIGATIONS AND CLEARANCE RECORD			YES	NO
a Has the U.S. Government or a foreign government EVER investigated your background and/or granted you a security clearance? If "Yes," use the codes that follow to provide the requested information below. If "Yes," but you can't recall the investigating agency and/or the security clearance received, enter the code for "Unknown." If your response is "No," or you don't know or can't recall if you were investigated and cleared, check the "No" box.			<input type="checkbox"/>	<input checked="" type="checkbox"/>
Investigating Agency Codes 1 - Defense Department 2 - State Department 3 - Office of Personnel Management 4 - Federal Bureau of Investigation 5 - Treasury Department 6 - Department of Homeland Security 7 - Foreign government (<i>Specify country</i>) 8 - Unknown 9 - Other (<i>Explain below</i>)	Security Clearance Codes 0 - Not Required 1 - Confidential 2 - Secret 3 - Top Secret 4 - Sensitive Compartmented Information 5 - Q 6 - L 7 - Issued by foreign country (<i>specify country</i>) 8 - Unknown 9 - Other (<i>Explain below</i>)			
Month/Year	Agency Code	Foreign Government or Other Agency <i>(If necessary)</i>	Clearance Code	
#1				
#2				
#3				
#4				
			YES	NO
b To your knowledge, have you EVER had a clearance or access authorization denied, suspended, or revoked; or been debarred from government employment? If "Yes," give the action(s), date(s) of action(s), agency(ies), and circumstances. Note: An administrative downgrade or termination of a security clearance is not a revocation.			<input type="checkbox"/>	<input type="checkbox"/>
Month/Year	Department or Agency Taking Action	Circumstances		
#1				
#2				
26 FINANCIAL RECORD			YES	NO
For the following, answer for the last 7 years, unless otherwise specified in the question. Disclose all financial obligations, including those for which you are a cosigner or guarantor, on the following page.				
a Have you filed a petition under any chapter of the bankruptcy code? If "Yes," indicate type.			<input type="checkbox"/>	<input checked="" type="checkbox"/>
b Have you had any possessions or property voluntarily or involuntarily repossessed or foreclosed?			<input type="checkbox"/>	<input checked="" type="checkbox"/>
c Have you failed to pay Federal, state, or other taxes, or to file a tax return, when required by law or ordinance?			<input type="checkbox"/>	<input checked="" type="checkbox"/>
d Have you had a lien placed against your property for failing to pay taxes or other debts?			<input type="checkbox"/>	<input checked="" type="checkbox"/>
e Have you had a judgment entered against you?			<input type="checkbox"/>	<input checked="" type="checkbox"/>
f Have you defaulted on any type of loan?			<input type="checkbox"/>	<input checked="" type="checkbox"/>
g Have you had bills or debts turned over to a collection agency?			<input type="checkbox"/>	<input checked="" type="checkbox"/>
h Have you had any account or credit card suspended, charged off, or cancelled for failing to pay as agreed?			<input type="checkbox"/>	<input checked="" type="checkbox"/>
i Have you been evicted for non-payment of financial obligations?			<input type="checkbox"/>	<input checked="" type="checkbox"/>
j Have you been delinquent on court-imposed alimony or child support payments?			<input type="checkbox"/>	<input checked="" type="checkbox"/>
k Have you had your wages, benefits, or assets garnished or attached for any reason?			<input type="checkbox"/>	<input checked="" type="checkbox"/>
l Have you been counseled, warned, or disciplined for violating terms of agreement for a travel or credit card provided by your employer?			<input type="checkbox"/>	<input checked="" type="checkbox"/>
m Have you been over 180 days delinquent on any debt(s)?			<input type="checkbox"/>	<input checked="" type="checkbox"/>
n Are you currently over 90 days delinquent on any debt(s)?			<input type="checkbox"/>	<input checked="" type="checkbox"/>
o Have you EVER experienced financial problems due to gambling?			<input type="checkbox"/>	<input checked="" type="checkbox"/>
p Are you currently delinquent on any Federal debt?			<input type="checkbox"/>	<input checked="" type="checkbox"/>

Enter your Social Security Number before going to the next page ➔

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QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

26 FINANCIAL RECORD (Continued)
 For the following, answer for the last 7 years, unless otherwise specified in the question. Disclose all financial obligations, including those for which you are a cosigner or guarantor. If you answered "Yes" on the previous page (a-p), provide the information requested below. For each "Yes" answer, provide the corresponding letters.

Indicate (a-p)	Date Satisfied Month/Year	Amount of Property Value Involved	Loan/Account Number/ Bankruptcy Type	Names of Agency/Organization/Individual to Whom Debt is/was Owed	
#1					
Name/Address of Company, Court, or Agency Handling Case				Name Action/Debt is Recorded Under	Status of Action or Debt
State				ZIP Code	
#2					
Name/Address of Company, Court, or Agency Handling Case				Name Action/Debt is Recorded Under	Status of Action or Debt
State				ZIP Code	
#3					
Name/Address of Company, Court, or Agency Handling Case				Name Action/Debt is Recorded Under	Status of Action or Debt
State				ZIP Code	
#4					
Name/Address of Company, Court, or Agency Handling Case				Name Action/Debt is Recorded Under	Status of Action or Debt
State				ZIP Code	

27 USE OF INFORMATION TECHNOLOGY SYSTEMS

The following questions ask about your use of information technology systems. Information technology systems include all related computer hardware, software, firmware, and data used for the communication, transmission, processing, manipulation, storage, or protection of information. 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 or without proper authorization entered into any information technology system?		X
b In the last 7 years, have you illegally or without authorization modified, destroyed, manipulated, or denied others access to information residing on an information technology system?		X
c In the last 7 years, have you introduced, removed, or used hardware, software, or media in connection with any information technology system without authorization, when specifically prohibited by rules, procedures, guidelines, or regulations?		X

Date of Incident (Month/Year)	Nature of Incident/Offense	Location Incident Took Place	Action Taken
#1			
#2			
#3			
#4			
#5			
#6			
#7			

Enter your Social Security Number before going to the next page →

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**QUESTIONNAIRE FOR
 NATIONAL SECURITY POSITIONS**

28 INVOLVEMENT IN NON-CRIMINAL COURT ACTIONS				YES	NO
In the last 7 years (if an SSBI go back 10 years), have you been a party to any public record civil court action(s) not listed elsewhere on this form?				<input type="checkbox"/>	<input checked="" type="checkbox"/>

If you answered "Yes," provide the information about each public record civil court action(s) requested below.

Month/Year	Nature of Action	Result of Action	Name of Principal Parties Involved (if more space is needed, use Continuation Space on page 17)	Court Information
#1				Court name
				Street address
				City State ZIP Code
#2				Court name
				Street address
				City State ZIP Code

29 ASSOCIATION RECORD

The following questions pertain to your associations. 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. For the purpose of this question, terrorism is defined as any criminal acts that involve violence or are dangerous to human life and appear to be intended to intimidate or coerce a civilian population to influence the policy of a government by intimidation or coercion, or to affect the conduct of a government by mass destruction, assassination or kidnapping.

a Have you EVER been an officer or a member of, or made a contribution to, an organization dedicated to terrorism, and which engaged in illegal activities to that end, either with an awareness of the organization's dedication to that end or with the specific intent to further such illegal activities?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b Have you EVER been an officer or a member of, or made a contribution to, an organization dedicated to the use of violence or force to overthrow the U.S. Government, and which engaged in illegal activities to that end, either with an awareness of the organization's dedication to that end or with the specific intent to further such illegal activities?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c Have you EVER been an officer or a member of, or made a contribution to, an organization that unlawfully advocates or practices the commission of acts of force or violence to discourage others from exercising their rights under the U.S. Constitution or any state of the U.S. with the specific intent to further such unlawful activities?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d Have you EVER advocated any acts of terrorism or activities designed to overthrow the U.S. Government by force with the specific intent to incite others to unlawful action in furtherance of such aims?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e Have you EVER knowingly engaged in any activities designed to overthrow the U.S. Government by force?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
f Have you EVER knowingly engaged in any acts of terrorism? Neither your truthful response nor information derived from your response to this question will be used as evidence against you in any subsequent criminal proceeding.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
g Have you EVER participated in militias (not including official state government militias) or paramilitary groups?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

If you answered "Yes" to any of the questions above, explain below.

CONTINUATION SPACE

Use the continuation sheet(s) (SF 86A) for additional answers for items 11, 12, and 13. Use the space below to continue answers to all other items and to provide any information you would like to add. If more space is needed than is provided below, use a blank sheet(s) of paper. Start each sheet with your name and SSN. Before each answer, identify the number of the item and try to maintain question format.

After completing this form and any attachments, you should review your answers to all questions to make sure the form is complete and accurate, and then sign and date the following certification and the attached release(s).

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 have carefully read the foregoing instructions to complete this form. 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 may have a negative effect on my security clearance, employment prospects, or job status, up to and including denial or revocation of my security clearance, or my removal and debarment from Federal service.

Signature		Date (mm/dd/yyyy) Sign when you get here.
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Enter your Social Security Number before going to the next page → 123-45-6789

**QUESTIONNAIRE FOR
 NATIONAL SECURITY POSITIONS**

UNITED STATES OF AMERICA

AUTHORIZATION FOR RELEASE OF INFORMATION

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

I Authorize any investigator, special agent, or other duly accredited representative of the authorized Federal agency conducting my background investigation, to obtain any information relating to my activities from individuals, schools, residential management agents, employers, criminal justice agencies, credit bureaus, consumer reporting agencies, collection agencies, retail business establishments, or other sources of information. This information may include, but is not limited to, my academic, residential, achievement, performance, attendance, disciplinary, employment history, criminal history record information, and financial and credit information. I authorize the Federal agency conducting my investigation to disclose the record of my background investigation to the requesting agency for the purpose of making a determination of suitability or eligibility for a national security position.

I Authorize the Social Security Administration (SSA) to verify my Social Security Number (to match my name, Social Security Number, and date of birth with information in SSA records and provide the results of the match) to the Office of Personnel Management (OPM) or other Federal agency requesting or conducting my investigation for the purposes outlined above. I authorize SSA to provide explanatory information to OPM, or to the other Federal agency requesting or conducting my investigation, in the event of a discrepancy.

I Understand that, for financial or lending institutions, medical institutions, hospitals, health care professionals, and other sources of information, separate specific releases may be needed, and I may be contacted for such releases at a later date.


I Authorize any investigator, special agent, or other duly accredited representative of the OPM, the Federal Bureau of Investigation, the Department of Defense, the Department of State, and any other authorized Federal agency, to request criminal record information about me from criminal justice agencies for the purpose of determining my eligibility for assignment to, or retention in, a national security position, in accordance with 5 U.S.C. 9101. I understand that I may request a copy of such records as may be available to me under the law.

I Authorize custodians of records and other sources of information pertaining to me to release such information upon request of the investigator, special agent, or other duly accredited representative of any Federal agency authorized above regardless of any previous agreement to the contrary.

I Understand that the information released by records custodians and sources of information is for official use by the Federal Government only for the purposes provided in this Standard Form 86, and that it may be disclosed by the Government only as authorized by law.

Photocopies of this authorization that show my signature are valid. This authorization is valid for five (5) years from the date signed or upon the termination of my affiliation with the Federal Government, whichever is sooner.

Signature (<i>Sign in ink</i>) Wait until you arrive to sign.		Full name (<i>Type or print legibly</i>) Arleigh Arnold Burke		Date signed (<i>mm/dd/yyyy</i>) Wait until you arrive	
Other names used				Date of birth 10/19/1901	Social Security Number 123-45-6789
Current street address 123 Main St.	Apt. #	City (<i>Country</i>) Boulder (USA)	State CO	ZIP Code 80302	Home telephone number 303-123-4567

Enter your Social Security Number before going to the next page 

123-45-6789

**QUESTIONNAIRE FOR
NATIONAL SECURITY POSITIONS**

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

If you answered "Yes" to Question 21, 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 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 national security 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 U.S. Office of Personnel Management. 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 86 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.

Photocopies 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 (<i>Sign in ink</i>) Wait until you arrive to sign.		Full name (<i>Type or print legibly</i>) Arleigh Arnold Burke		Date signed (<i>mm/dd/yyyy</i>) Wait until you arrive	
Other names used			10/19/1901		Social Security Number 123-45-6789
Current street address	Apt. #	City (<i>Country</i>)	State	ZIP Code	Home telephone number
123 Main St.		Boulder (USA)	CO	80302	303-123-4567

For Use By Practitioner(s) Only

Does the person under investigation have a condition that could impair his or her judgment, reliability, or ability to properly safeguard classified national security information?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, describe the nature of the condition and the extent and duration of the impairment or treatment.		
What is the prognosis?		
Signature (<i>Sign in ink</i>)	Practitioner name	Date signed (<i>mm/dd/yyyy</i>)

Print Form

Clear Form

Enter your Social Security Number before going to the next page →

123-45-6789

UNITED STATES NAVY TATTOO SCREENING CERTIFICATE

Only fill this form out if you are Navy option.

NAME (Last, First, Middle, Jr., etc.) Burke, Arleigh, A	Date: 6/01/2016
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	YES	NO
1. Does the applicant/candidate have any tattoos/body art/branding?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Is any tattoo/body art/brand exposed on the neck while wearing a properly fitted crew neck T-shirt?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Does any tattoo/body art/brand visible while wearing a crew neck T-shirt or Navy Service Uniform exceed the area of the wearer's hand, with fingers extended and joined with the thumb touching the base of the index finger?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Has the applicant/candidate ever had any tattoo, body art or brand removed?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Any "Yes" response to item 2, 3, or 4 above requires an enlistment eligibility determination by NAVCRUITDIST CO.

	YES	NO
5. Are any of the tattoos/body art/brands on the neck, face (excluding cosmetic tattoos) or scalp?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Are any of the tattoos/body art/brands visible above the collar of a properly fitted open collar uniform shirt? (Excluding cosmetic tattoos)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. If applicable, are cosmetic tattoos applied in good taste with natural color enhancement and of a conservative nature?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Are any of the tattoos/body art/branding representative of gang membership, advocate racial, ethnic, racial discrimination, sexism (including expressions of nudity), drug related, obscene, or are prejudicial to good order, discipline, and morale, or are of a nature to bring discredit upon the Navy?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Are any of the tattoos a result of a specific activity? (i.e., specifically an illegal activity or as a result of any violation of law (s))	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Any "Yes" response to items 5, 6, 8, or 9 above is disqualifying, not authorized for Enlistment. Any "No" response to Item 7 is disqualifying, not authorized for Enlistment.

NOTE: All **questionable body markings**, due to content, size, number, and/or location, shall be forwarded to NAVCRUITCOM for eligibility determination.

Applicant Signature <i>Sign here</i>	Date <i>Today's date</i>	Recruiter Signature	Date
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Description of tattoos, brands, and/or body ornamentation:

American Bald Eagle tattoo on chest - 3 inches in diameter.

31 knot burke tattoo on shoulder.

Explain tattoo, brand, and/or body ornamentation removal process, if applicable.

CO/XO/R-OPS/EPDS Reviewing Comments:

CO/XO/R-OPS/EPDS Signature	Typed Name:	Date:
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Only fill out if you are a Marine Option

MCRC OFFICER TATTOO SCREENING FORM

NAME _____ L4 SSN _____ DATE _____

Part I. Purpose. The purpose of this form is to ensure that you tell us the full extent of your tattoos, brands and/or body ornamentation. Refusal to complete the form will result in termination of your officer commissioning processing.

1. Does the candidate currently have, or ever had any tattoos, brands, body markings, or body ornamentation, or has the candidate ever had a tattoo, brand or body ornamentation removed, concealed, covered or altered? (Initials in appropriate block)

Y AAB N _____

If answer to Question 1 is NO; the candidate will move to Part II Certification Block of this Screening Form. Questions 2 through 9 are not required.

2. Does candidate have **any tattoos, brands, markings or ornamentations** of any type?

Y AAB N _____

3. Are any of the tattoos, brands or markings:

- on head or neck (above collarbone in front, above seventh [C7] cervical [last] vertebrae in back or otherwise visible in open collar short sleeve khaki shirt with no undershirt) or inside the mouth?

- on hands, fingers, or wrists ?

Y _____ N AAB

4. Are any tattoos, markings or ornamentations exposed while wearing the standard PT uniform:

- Larger than wearers hand with fingers extended and joined?

- Band Tattoos, (max width 2" or less)?

- Excessive Tattoos (combined coverage more than 1/4 of the body part)?

- Sleeve Tattoos (large tattoos or collection of smaller tattoos that covers or almost covers a person's arm[s] or leg[s])?

Y _____ N AAB

5. Do any of the tattoos, markings etc., depict nudity, are they racist, eccentric, offensive in nature, or express an association with conduct or substances prohibited by the Marine Corps Drug policy, the UCMJ, to include tattoos associated with illegal drugs, drug usage or paraphernalia?

Y _____ N AAB

6. Do any of the tattoos, brands or body ornamentation represents a gang membership or extremist group, advocate racial, ethnic, or religious discrimination, obscene, prejudicial to good order and discipline/morale or of a nature to discredit to the Marine Corps?

Y _____ N AAB

Explain: _____

7. Are any of the tattoos a result of a specific activity? (i.e. activity for membership initiation, or as the result of any violation of law(s))?

Y _____ N AAB

8. Are there any body markings, ornamentation or mutilation (i.e. Tongue Splitting, etc), Ornamental Body Piercing(s), Holes in Ear Lobes (large enough for light to pass through opening), or Ornamental Implantations, (silicon implants on face, horns on the forehead, etc).

Y _____ N AAB

9. Have any tattoos, brands, markings or body ornamentation been removed, concealed, covered or altered?

Y _____ N AAB

MCRC OFFICER TATTOO SCREENING FORM

NAME _____ **L4 SSN** _____ **DATE** _____

Location(s) of a candidate's current, removed, concealed, covered, or altered tattoos, brands, markings or ornamentation will be documented in **Part IV** of this Screening Form. Removed, concealed, covered or altered tattoos need to be annotated as such (i.e. removed) with full description of the original marking.

Part II: Certification. I have completely disclosed the full extent of my tattoos, brands or body ornamentation to include those removed or altered.

 (Signature of Candidate)

 (Date)

 (Name of Commissioned Officer)

 (Signature)

 (Date)

Note: IF CANDIDATE RESPONDED "YES" TO QUESTIONS 1, or QUESTION 2, MUST BE INTERVIEWED BY COMMISSIONED OFFICER TO DETERMINE ELIGIBILITY AND FOR REVIEW BY REGIONAL COMMANDING GENERAL. IF CANDIDATE RESPONDED "YES" TO QUESTIONS 3 THROUGH 8, THE CANDIDATE IS INELIGIBLE FOR COMMISSIONING. DIGITAL PHOTOS ARE REQUIRED FOR ALL REVIEWS. Photos not required of female candidates with torso tattoos or male candidates with lower torso (below waist) tattoos. Candidates may hand draw pictures of torso & lower torso tattoos indicating size and location. Cross-check drawings with DD Form 2808 Medical Examination, Block 37 documents for consistency. Under no circumstances will a female candidate be photographed in less clothing than the standard PT uniform of shorts & shirt (with sleeves rolled to shoulder seam)/tank top (with spaghetti straps) and PT shorts or any male candidate be photographed in less clothing than standard PT uniform (shorts).

Commissioned Officer's Reviewing Comments: _____

NAME/SIGNATURE OF COMMISSIONED OFFICER

RANK

BILLET

Recruiting Station Review (if applicable)

Regional CG Review required (if applicable)

ALL QUESTIONABLE BODY MARKINGS ON REGARDING CONTENT, SIZE, NUMBER OR LOCATION WILL BE FORWARDED TO THE APPROPRIATE DECISIONING AUTHORITY FOR APPROVAL/REVIEW.

***Note: Part III. Recertification.** Officer Program Candidates. I certify the information previously given on Tattoo Screening Form remains the same. If any change is indicated an addendum Tattoo Screening Form will be completed forwarded to the Commanding Officer prior to shipment to officer candidate training .

1. Changes to this Tattoo Screening Form **Y**_____ **N** _____

 (Signature of Candidate)

 (Last 4 SSN)

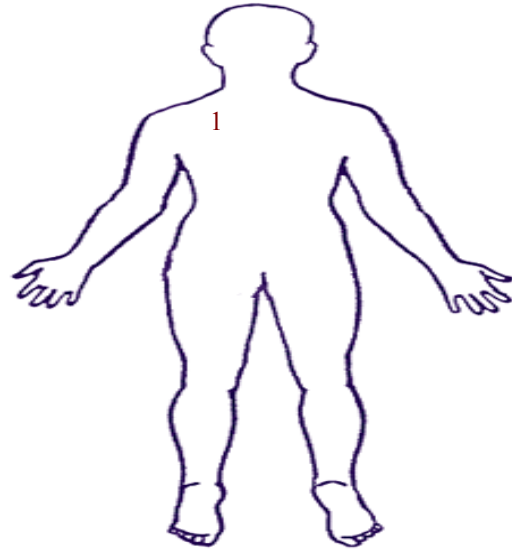
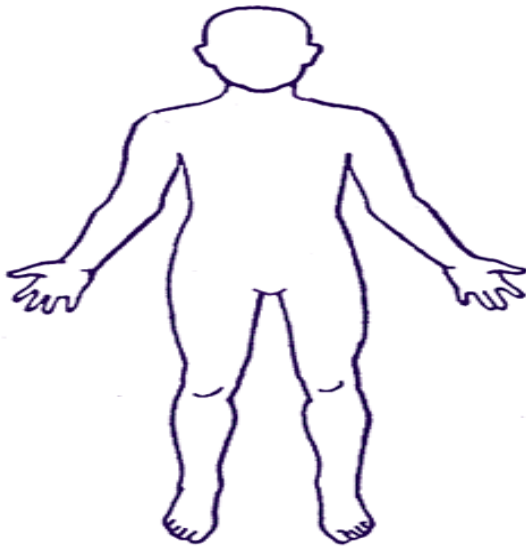
 (Date)

 (Name of Certifying Officer)

 (Signature)

 (Date)

Part IV. Documentation. The following depicts the location and description of the candidate's Body Markings. Place number on body location and describe in blocks below indicating content and size in inches:



FRONT VIEW

BACK VIEW

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Part V. Certification. I certify above body marking information is accurate.

 (Name of Candidate) *Arleigh G. Burke* _____
 (Signature of Candidate) (Date)

I certify body marking documentation is in accordance with MARADMIN 029/10.

 (Name of Commissioned Officer) (Signature of Commissioned Officer) (Date)

**NAVAL RESERVE OFFICERS TRAINING CORPS DRUG AND ALCOHOL
STATEMENT OF UNDERSTANDING**

Authority: 5 U.S.C. 301 (Authorizing Forms and Regulations); 10 U.S.C. 2103 (Eligibility for Membership), 2104 (Eligibility for Advanced Training), 2107 (Senior ROTC Financial Assistance Program), 2122 (Eligibility for Health Professions Scholarship and Financial Assistance Program); Executive Order 9397 (Use of Social Security Numbers); OPNAVINST 5350.4D (Navy Alcohol and Drug Abuse Prevention and Control); and NSTC M-1533.2 at 2-27 and 2-28.

Principal Purposes: To obtain information used to evaluate an individual's compliance with policy and fitness for service as a commissioned officer.

Routine Uses: Those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act and the routine uses set forth in 32 C.F.R. 701.112.

Disclosure: Disclosure is voluntary. However, failure to provide the requested information may result in adverse administrative action and/or ineligibility for, or disenrollment from, the NROTC Program.

STATEMENT OF UNDERSTANDING

I, _____ understand the following:
(Full name – first, middle, last)

1. Participation in the Naval Reserve Officer Training Corps (NROTC) places me in a position of special trust and responsibility.
2. As established by OPNAVINST 5350.4D, the abuse of drugs or alcohol violates this position of special trust and endangers my health and safety as well as the safety of others.
3. In accordance with OPNAVINST 5350.4D, Naval Service Training Command (NSTC) maintains a "zero tolerance" policy regarding drug abuse. Additionally, all misconduct resulting from the misuse of alcohol will be dealt with immediately and effectively.
4. As a student participating or enrolled in the NROTC Program as a NROTC Midshipman (MIDN), NROTC College Program Student (Basic or Advanced), or Strategic Sealift Officer Program, I understand and agree to be bound by NSTC's policy regarding drug and alcohol abuse as reflected in the Regulations for Officer Development, NSTC M-1533.2. Additionally, I understand I will be screened by urinalysis within 30 days of first reporting for training to the NROTC unit to which I have been assigned and may be subject to random urinalysis screening as directed by NSTC.
5. By signing the certification below, I acknowledge that a single detection of drug abuse or incident of alcohol abuse after entry into any program listed within paragraph 4 may result in my disenrollment or removal from that program, and, if on scholarship, either the recoupment of all scholarship monies I have received or Active Enlisted Service as may be directed by the Secretary of the Navy.

CERTIFICATION

I have read and fully understand all the information contained on this form.

Typed/Printed Name (last, first, middle)

Signature:

Date:

CERTIFYING OFFICIAL AND WITNESS

I certify the above individual signed this certificate in my presence.

Typed/Printed Name and Title of Official Certifying

Signature:

Date:

Typed/Printed Name and Title of Witness

Signature:

Date:

NAVAL RESERVE OFFICERS TRAINING CORPS
ACCEPTANCE AND OATH OFFICE

Privacy Act Statement

Authority: The authority to request this information is contained in: 5 USC § 301 (Authorizing Forms and Regulations) and 10 USC Sec. 2104, Subtitle A, Part III, Chapter 103 (Senior ROTC).

Principal Purpose(s): Used when administering the acceptance and oath of office for new Naval Reserve Officers Training Corps (NROTC) Midshipman.

Routine Purpose(s): Information you provide in this application is protected by the Privacy Act and will not be released outside the Department of Defense without your permission unless it comes within an exception to the Act or one of the routine uses in 32 CFR § 701.112, <http://www.privacy.navy.mil> and the routine uses set forth here.

Disclosure: Failure to provide the requested information may result in removal from the NROTC program and/or loss of scholarship benefits.

ACCEPTANCE

I, _____, having been permanently appointed as
Midshipman, (USNR/USMCR) from the _____ day of _____, _____ do
accept such appointment.

APPOINTEE SIGNATURE

OATH OF OFFICE

I, _____, having been appointed a midshipman, do
solemnly swear (or affirm) that I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear
true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and
faithfully discharge the duties of office on which I am about to enter: So help me God.

APPOINTEE SIGNATURE

Subscribed and sworn to before me this _____ day of _____, _____.

WITNESSING OFFICER PRINTED NAME

WITNESSING OFFICER SIGNATURE

NAVAL RESERVE OFFICERS TRAINING CORPS
SCHOLARSHIP CONTRACT

Privacy Act Statement

AUTHORITY: The authority to request this information is contained in: 5 USC § 301 (Authorizing Forms and Regulations), Executive Order 9397 (Use of Social Security Numbers), and 10 USC § 2107 (Senior ROTC Financial Assistance Program).

PRINCIPAL PURPOSE(S): The primary use of this information is by officials to administer the Naval Reserve Officers Training Corps (NROTC) Program and to set forth the terms and conditions, including military service obligations under which the Navy will be providing an NROTC scholarship.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 USC § 552a(b) of the Privacy Act and the routine uses set forth in 32 CFR § 701.112, these records or information contained therein may be disclosed outside the Department of Defense to officials and employees of the college or university in which you enroll, and those of the Veterans Administration, and Selective Service Administration in the performance of their official duties related to enlistment and reenlistment eligibility and related benefits.

DISCLOSURE: Disclosure is voluntary. However, failure to provide the requested information may result in ineligibility for, and/or disenrollment from, the NROTC Program.

This contract (the "Contract") is by and between the Department of the Navy (the "Navy") and _____
Full Name (Last, First, Middle)
_____ (the "Student") and sets forth the terms and conditions of the Student's participation in the Naval Reserve
Social Security Number

Officers Training Corps ("NROTC") Program (the "NROTC Program"). The Contract is effective as of the first day of the academic term in which it is signed (the "Effective Date"). The Student is attending _____ (the "School"), is assigned to the NROTC unit located at _____ (the "Unit") and is pursuing an academic major leading to a baccalaureate degree that falls in the following tier of preferred academic majors (the "Tier")

(NOTE: The Tier was identified in the writing sent to the Student, notifying them they would be receiving an NROTC scholarship) (Check one) :

____ Tier 1/Tier 2

____ Tier 3 ____ Language Regional Expertise and Culture Program Tier 3

The Student will be participating in the following NROTC Program (check one):

____ Navy Option ____ Marine Corps Option ____ Navy Nurse Option

1. **PURPOSE.** The Navy and the Student agree that the purpose of this Contract is for the Navy to provide the educational assistance identified in Paragraph 2.a. (collectively, the "Scholarship Benefits") to the Student in exchange for the Student's agreement to serve in the United States Navy or Marine Corps as a commissioned officer and to comply with all other Contract terms and conditions. For clarity, the Contract refers to the Student in the first person.

2. **SCHOLARSHIPS**

a. **Scholarship Benefits.** Subject to the terms and conditions in this Contract, the Navy will provide the following Scholarship Benefits:

(1) **Tuition and Fees.** The Navy will pay all tuition and fees charged by the School for courses I take and all mandatory fees (such as health, student activity, library and transcript fees) imposed by the School on *all* full-time undergraduate students, which I cannot refuse but am obligated to pay. The Navy will not pay for:

(a) Any fee that I incur because I withdrew from a course, or any course that I repeat because I initially failed the course, or any course from which I withdrew after a time when I could have received tuition credit or reimbursement, or any course that I am retaking in an effort to receive a better grade;

(b) Any fees or tuition above or in addition to those normally charged that are for an elective course (such as horseback riding or skiing) not required to complete my degree requirements or to fulfill any NROTC Program requirements, unless my Unit's Professor of Naval Science ("PNS") has determined in writing before I enroll in the course that taking the course would improve my understanding of a technical or scientific subject;

(c) Refundable fees, such as deposits required to secure the use of an apparatus used in coursework;

(d) Charges I incur for breaking or damaging property;

(e) Fees assessed by the School for my failure to comply with any School requirement;

(f) Fees for advanced placement examinations, unless my Unit's PNS has determined in writing before I take such an examination, that I will thereby receive credit for courses required to complete my Tier that will enable me to receive my commission earlier than scheduled under this Contract, in which case the Navy will reimburse me for such fees; or

(g) Medical or dental insurance.

(2) **Books.** Each Academic Year, the Navy will pay me a book allowance in the amount then prescribed by the NROTC Program. For purposes of this Contract, "Academic Year" is defined as that period which begins on the first day of the School's fall term and ends on the last day of the School's spring term, including the time during which I am taking required and scheduled end of term examinations.

NAVAL RESERVE OFFICERS TRAINING CORPS
SCHOLARSHIP CONTRACT (continued)

(3) Monthly Subsistence Allowance. During my freshman year, the Navy will pay me a monthly subsistence allowance in the amount then prescribed by law and regulation. The amount of this allowance increases as I attain higher academic rank (sophomore, junior or senior) and may be changed by law or regulation during the term of this Contract. I understand that I will not be receiving such an allowance for the period of time when I am on summer training or at-sea training, times during which I am considered to be on active duty and will receive training pay.

(4) Training Pay and Travel Costs. The Navy will pay me for participating in summer training or at-sea training, times when I am considered to be on active duty, at the rate established for U.S. Naval Academy midshipmen. I will be entitled to such pay from the day I arrive at the training site to the day I depart. I understand that I am not eligible for training pay while I am traveling to and from the training site. I also understand that my travel costs to and from the training site are payable by the Navy in accordance with applicable travel regulations.

(5) Uniforms. The Navy will pay for the military uniform items prescribed for NROTC Program midshipmen by the Navy Uniform Regulations or, if I am a Marine Corps Option Student, by the applicable Marine Corps Order. I understand that I will control and dispose of these items in accordance with the NROTC Program's Regulations for Officer Development, Naval Service Training Command Instruction 1533.2 as now issued and as amended from time to time (the "Regulation"). I understand that this Scholarship Benefit is limited to military uniforms only and that I am responsible for purchasing any other item of clothing required by my Tier or for any course of study.

b. Term of Scholarship Benefits. The Navy will begin providing me Scholarship Benefits on the first day of the first full academic term during which this Contract is in effect and will continue to do so for the period of time remaining until I receive a baccalaureate degree in my Tier. I understand and agree, however, that the Navy will provide the Scholarship Benefits for an Academic Year of up to ten (10) months (prorated the first Academic Year if I will not have been an NROTC Scholarship Student the entire Academic Year). I further acknowledge and agree that the Navy will not provide Scholarship Benefits for a total of more than forty (40) months (or, if I have been awarded a scholarship after I have begun my freshman year for the lesser period of time set forth in the writing that notified me I had been awarded an NROTC scholarship) unless I have requested a waiver in writing via my PNS and have been granted such a waiver in writing from Commander, Naval Service Training Command.

3. ELIGIBILITY

a. Initial Eligibility for Scholarship Benefits. I understand and agree that I must meet certain criteria to qualify for the Scholarship Benefits. I therefore warrant and represent that I:

- (1) Am a citizen or a national of the United States of America;
- (2) Have a high school diploma or an equivalent certificate;
- (3) Have been accepted by, and am enrolled as a full time student in, the School;
- (4) Am pursuing a course of study leading to a baccalaureate degree in the Tier;

(5) Have no moral objections or personal convictions that will prevent me from obligating myself to bear arms and support and defend the Constitution of the United States against all enemies, foreign and domestic and I agree to take an oath obligating myself to perform such acts;

(6) Have undergone a physical examination and have either (A) been found physically qualified to participate in the NROTC Program by a Department of Defense Medical Examination Review Board medical professional or (B) secured a waiver from the Navy for any disqualifying physical condition;

(7) Have no condition that would disqualify me from military service as an officer or as an enlisted member;

(8) Will be (A) at least 17 years of age on or before 1 September in the year in which I first enroll in the NROTC Program and (B) under 27 years of age on June 30 of the year I receive my commission; and

(9) Have disclosed **all** information that may reasonably affect my eligibility for military service.

b. Continuing Eligibility for Scholarship Benefits. To continue receiving Scholarship Benefits following my initial selection, I must:

- (1) Be enrolled as a full-time student in, and remain in good standing with, the School, fulfilling all academic requirements;
- (2) Continue to pursue a baccalaureate degree in the Tier and not change my major, the type of degree I am pursuing or my Tier without the express prior written consent of my PNS;

(3) If I have been selected as a recipient of a Two-Year NROTC scholarship (as defined in the Regulation), I must take and complete the prescribed Naval Science Institute course during the summer before I am enrolled in the NROTC Program and am appointed a midshipman;

(4) Enlist in the U.S. Navy Reserves or U.S. Marine Corps Reserve (the "Reserves") as specified in Paragraph 5 of this Contract;

(5) Remain qualified for military service as an officer, meeting all applicable requirements;

(6) Not be in a leave of absence from, and remain in good standing with, the Unit, fulfilling all NROTC Program requirements, including those set forth in the Regulation; and

(7) Demonstrate active participation in the NROTC Program at the beginning of each Academic Year. I will be considered an active participant under this paragraph if, for the first 45 days of each Academic Year, I am enrolled and participating in all aspects of the NROTC Program, including but not limited to, school courses, Naval Science courses and drill. Failure to comply with this 45-day requirement will (A) render me ineligible to receive any Scholarship Benefits for the fall academic term, meaning that I will be liable for any costs assessed by the School; and (B) make my eligibility for Scholarship Benefits for any future academic terms or course(s) of study voidable at the sole discretion of the Navy.

NAVAL RESERVE OFFICERS TRAINING CORPS
SCHOLARSHIP CONTRACT (continued)

4. INTERSERVICE TRANSFER/REASSIGNMENT TO A DIFFERENT NROTC UNIT

a. To a Non-Navy/Marine Corps NROTC Program. If I request a transfer to the ROTC program of a military service other than the Navy or Marine Corps, I understand that the Navy will treat this as a request for disenrollment from the NROTC Program.

b. To a Different NROTC Unit or NROTC Program School. If I request a transfer to a different NROTC unit or to a different educational institution that participates in the NROTC Program, I understand that the Navy will process my request in accordance with the Regulation. Such a transfer requires, among other things, the prior, written consent of the commanding officers of both the losing and gaining NROTC units. No such transfer shall be considered approved or effective without the prior, written consent of an authorized Navy official.

5. MILITARY SERVICE OBLIGATIONS. I understand and agree that, if I am signing this Contract during my first year of college, the commitment point after which I may not withdraw or be withdrawn from the NROTC Program without incurring any military service or reimbursement obligations is the first day the Naval Science class convenes during my sophomore year, whether or not I am physically present at that class. In all other cases, this commitment point will commence and be binding upon the Effective Date of this Contract. I will incur these military service or reimbursement obligations if I have not withdrawn from the NROTC Program by the time of that commitment point. Once this commitment point has occurred, I will become subject to the military service requirements set forth in Paragraph 5.b, and to the reimbursement or active enlisted service obligations set forth in Paragraph 6.

a. Enlistment in the Reserves. I understand and agree to enlist in the U.S. Navy or Marine Corps Reserves as follows:

(1) Entering the NROTC Program from Civilian Life. If I am entering the NROTC Program from civilian life, I will sign a DD Form 4 (or any forms then used by the Department of Defense to accomplish the same purpose), enlisting for eight (8) years from my date of enlistment.

(2) Entering the NROTC Program From Active or Inactive Duty

(a) From Active Duty. If I am entering the NROTC Program from active duty, I will be conditionally released from my active duty obligation and will sign a new enlistment contract for the period of time that I will be in the NROTC Program. On signing the new enlistment contract, I will be transferred to the Reserves, subject to the provisions of Paragraph 5.a.(2)(c) below. This release and transfer will be effective as of the day prior to my first day of class at the School. I understand that during the time I participate in the NROTC Program, I will be entitled only to the Scholarship Benefits and no other payments or benefits. I further understand that my release from any active duty obligations is conditioned on my continued participation in the NROTC Program.

(b) From Inactive Duty. If I am entering the NROTC Program from a reserve component, I will be conditionally released from my enlistment contract, and will sign a new enlistment contract for the period of time I will be in the NROTC Program, subject to the provisions of paragraph 5.a.(2)(c) below. The new enlistment contract will provide that I will continue to serve in the reserve component but, during the period of time I am participating in the NROTC Program, I will be released from any drilling obligations and will not be called or ordered to active duty. This release and transfer will be effective as of the day prior to my first day of class at the School. I understand and agree that during the time I participate in the NROTC Program, I will be entitled only to the Scholarship Benefits and no other payments or benefits. I further understand and agree that my release from any active duty and drilling obligations is conditioned on my continued participation in the NROTC Program.

(c) Resumption of Previous Enlistment Obligation on Disenrollment. If I disenroll or am disenrolled from the NROTC Program, I will be required to serve any unexpired portion of my previous enlistment obligation according to its terms. I agree that my service as an NROTC midshipman will not be counted as service for purposes of fulfilling any existing enlisted service obligation and hereby waive any rights I may have under any law or regulation to the contrary. I understand that my completion of any unexpired enlistment obligation will not relieve me from the reimbursement or active enlisted service obligations described in Paragraph 6.

b. Commissioning as an Officer; Military Service Obligation. Upon my fulfillment of all Contract requirements, including my receipt of a baccalaureate degree in the Tier, and at the discretion of the Secretary of the Navy (the "**Secretary**"), I will be eligible for, and agree to accept a commission as, an officer in the U.S. Navy, either Restricted Line Officer (RL) or Unrestricted Line Officer (URL), or as an officer in the U.S. Marine Corps. The effective date of my commissioning (which may differ from the actual date I receive my commission) will be noted on the commissioning scroll as my date of rank ("**Date of Rank**"). I understand and agree that upon being commissioned, I will be discharged from my enlisted service obligation and incur a new military service obligation ("**MSO**") not to exceed eight (8) years from my Date of Rank. I understand that I cannot resign my commission before I complete this MSO. The time for me to report to duty and complete this MSO, however, may be extended at the discretion of the Secretary of the Navy if I am accepted into a program of graduate or professional study that would delay the commencement of my MSO. I further understand that my active duty service obligation will be extended if I am accepted into a program requiring additional military service and that I may be involuntarily retained on active duty in a time of war or national emergency. I will complete my MSO as follows:

(1) Active Duty Obligation. If offered a commission as a regular officer, I will serve on active duty for the following time period, depending on my NROTC Program status as identified in the preamble to this Contract:

- (a) If I am a Navy Option participant, five (5) years;
- (b) If I am a Marine Corps Option participant, four (4) years; and
- (c) If I am a Navy Nurse Program participant, four (4) years.

Whatever my program status, if my regular commission is terminated before the sixth anniversary of my Date of Rank, I will accept an appointment, if offered, in the reserve component of the Navy or Marine Corps and will not resign until I have fulfilled the remainder of my MSO.

(2) Reserve Assignment. If offered a commission in the reserve component of the Navy or U.S. Marine Corps, I will serve in that reserve component until I have fulfilled my MSO.

(3) Combination of Active and Reserve Duty Assignment. If offered a commission in the reserve component of the Navy or U.S. Marine Corps with an obligation to serve on active duty at least two years, I will serve as requested until I have fulfilled my MSO.

NAVAL RESERVE OFFICERS TRAINING CORPS
SCHOLARSHIP CONTRACT (continued)

(3) Secretary of the Navy Discretion. Notwithstanding anything to the contrary in this Paragraph 5, the Secretary, in his or her sole discretion, may determine that the needs of the Navy require that I be assigned to the Individual Ready Reserve (IRR) upon, or at any time after, my commissioning. My service in the IRR will count as fulfillment of my MSO, but not the active duty service obligation I incur under Paragraph 5.b.(1) above. If I am assigned to the IRR, I will be accumulating service time toward fulfillment of my active duty service obligation only during the time that I am activated for duty.

6. FAILURE TO FULFILL CONTRACT OBLIGATIONS; FAILURE TO COMMISSION

a. Reimbursement or Active Enlisted Duty Service Obligation. At the discretion of the Secretary of the Navy or his or her designee, I will be required to either (A) serve on active enlisted duty for a period of at least two (2) years or (B) reimburse the Navy for the cost of the tuition and fees I have incurred under Paragraph 2.a.(1), plus interest, if:

- (1) I fail to fulfill any terms or conditions of this Contract;
- (2) I become ineligible to serve as an officer prior to commissioning;
- (3) I am not offered a commission because the Navy has determined I lack the aptitude or am not suitable to be an officer;
- (4) I am disenrolled from the NROTC Program for any reason (including medical or physical disqualification); or
- (5) I refuse to accept a commission.

b. Non-dischargeable Debt. I understand that any reimbursement obligation I incur under this Contract is a debt to the United States of America and may not be dischargeable in bankruptcy.

7. GENERAL PROVISIONS

a. Subject to the Availability of Funds. The Navy's financial obligations under this Contract are contingent on the availability of appropriated funds from which payments due under this contract can be made. No legal liability on the part of the Navy for any payment may arise until funds are made available by Congress through the annual federal budget process and are then allocated to the NROTC Program.

b. Incorporation of Program Regulation by Reference. The most current version of the Regulation is hereby incorporated by reference as if fully set forth in this Contract. Any conflicts between the Regulation and this Contract will be resolved in favor of this Contract. A copy of the Regulation shall be made available to the Student by the Unit upon the Student's request.

c. Entire Agreement. This Contract represents the entire agreement of the parties concerning the matters addressed herein and supersedes any prior agreements, understandings, or representations.

d. Modification and Waiver. This Contract may be modified from time to time in writing signed by duly authorized representatives of each party. Oral modifications to this Agreement are not binding on any party. Unless expressly stated in a writing signed by a party, the waiver by a party of any act, duty, or obligation required under this Contract shall not be construed as a waiver of any other, or of any future, act, duty, or obligation to be performed by that party.

e. Captions and Headings. The captions and headings contained in this Contract are for reference purposes only and shall not affect in any way the interpretation of this Contract.

f. No Third Party Beneficiary. Nothing expressed or implied in this Contract is intended, or shall be construed, to confer upon or give any person or entity other than the Student and the Navy any rights or remedies by reason of, or under, this Contract.

g. Construction/Governing Law. This Contract is governed by, and shall be construed under, Federal law.

h. Divisibility. Any provision of this Contract declared or determined by any court, administrative tribunal or agency to be illegal or invalid will not affect the validity of the remaining provisions.

8. NOTICE. Unless otherwise stated in this Contract, notices required to be given to either party shall be effective upon receipt, must be in writing, and if mailed or sent via a courier service, must be addressed as follows:

Navy: _____

Command Name

Student: _____

Student Name

Address 1

Address 1

Address 2

Address 2

City, State Zip Code

City, State Zip Code

OPMIS INFORMATION

FULL NAME			
LAST: Burke		FIRST: Arleigh	MIDDLE: Arnold
303-123-4567 Personal Cell Number		Aerospace Engineering INTENDED MAJOR (on scholarship acceptance letter if applicable):	
Full SSN: (college program only)		STUDENT# If you know it.	arleigh.burke@colorado.edu colorado.edu email
123 Main St. Boulder, CO 80302 PERMANENT ADDRESS(HOME OF RECORD):			
DoD RACE*: White	ETHNICITY*: Y		HEIGHT: 72
WEIGHT: 160	BLOOD TYPE: A+	HAIR COLOR: Brown	EYE COLOR: Blue
BIRTH DATE: 10/10/1901	STATE OF BIRTH: CO	CITY OF BIRTH: Boulder	
US CITIZEN: YES /NO		ESTIMATED GRAD DATE: 05/2020	
STATE OF LEGAL RESIDENCE: CO		CIRCLE: NAVY OR MARINE CORPS	
PREVIOUS MILITARY SERVICE: YES / NO IF "YES", GRADE/RANK:			
PREVIOUS COLLEGE CREDITS: YES / NO IF "YES", HOW MANY: 12 AP credits			
UNIVERSITY/COLLEGE ATTENDED:			
SAT/ACT SCORES	MATH: 30	VERBAL: 28	COMPOSITE: 29
HAVE YOU EVER BEEN A MEMBER OF A JUNIOR ROTC: YES / NO IF "YES" SEE BELOW			
TYPE OF JUNIOR ROTC: F =AIR FORCE A =ARMY N =NAVY M =MARINE CORPS			
MARITAL STATUS: M =MARRIED D =DIVORCED S =SINGLE S			
NUMBER OF DEPENDENTS WHOM YOU ARE RESPONSIBLE FOR: 0 1 2 3 4 5			
EAGLE SCOUT: YES / NO		CHILD OF CAREER MILITARY MEMBER: YES / NO	
HIGH SCHOOL: Boulder High School		RECEIVED DIPLOMA: YES / NO	
HIGH SCHOOL PERCENTILE RANK: 1			
1 = TOP 20% 2 = TOP 40% 3 = TOP 60% 4 = TOP 80% 5 = BELOW TOP 80%			
HIGH SCHOOL TYPE: 2			
1 = PUBLIC (GRADUATING CLASS >100)		3 = PRIVATE (GRADUATING CLASS >100)	
2 = PUBLIC (GRADUATING CLASS <100)		4 = PRIVATE (GRADUATING CLASS <100)	
DEMOGRAPHIC TYPE: 2			
1 = URBAN(CITY >500,000) 2 = SURBURBAN(CITY <500,000) 3 = RURAL / COUNTRY			
EMERGENCY CONTACT INFORMATION			
NAME: Clara Burke		PHONE/DAY: 303-987-6543 PHONE/EVENING: 303-987-6543	
ADDRESS: 123 Main St. Boulder, CO 80302			

FOR OFFICIAL USE ONLY - PRIVACY SENSITIVE: ANY MISUSE OR UNAUTHORIZED DISCLOSURE MAY RESULT IN BOTH CIVIL AND CRIMINAL PENALTIES.

Enclosure (20)

DoD Race:

American Indian/Native American

Asian

Black/African American

Native Hawaiian/Other Pacific Islander

White

Decline to Respond

ETHNICITY CHOICES

8 - Aluet

3 - Asian American

G - Chinese

9 - Cuban

7 - Eskimo

5 - Filipino

H - Guamanian

D - Indian-Pakistani

J - Japanese

K - Korean

S - Latin American

E - Melanes

6 - Mexican

W - Micronesia

Y - None

X - Other

1 - Other Hispanic

Q - Other Pacific Islander

L - Polynesian

4 - Puerto Rico

Z - Unknown

2 - US/Canadian Native American

V - Vietnamese

Foreign Language Screening Form

Date: 6/2/2015

Phone Number: 303-123-4567

Last Name: Burke

First Name: Arleigh

No Self-Assessed Foreign Language Proficiency

<i>Foreign Language</i>	<i>Listening Skill</i>	<i>Speaking Skill</i>	<i>Reading Skill</i>	<i>Writing Skill</i>	<i>How Proficiency Obtained</i>
Spanish	1	1	1	1	A

SKILL LEVEL EVALUATION

0 – No proficiency/Memorized proficiency. The ability to understand and speak a small number of memorized statements or read numbers, isolated words, place names and/or street signs.

1 – Elementary proficiency. Basic traveling vocabulary. Able to understand and state very basic survival needs and few courtesy statements. Can read simple written material to include public announcements or simple newspaper headlines.

2 – Limited working proficiency. Can understand and respond to most social demands and conversations on work requirements. Can read most factual material. Usually more proficient with familiar topics.

3 – General professional proficiency. Understands most forms and styles of speech relating to professional needs as well as general topics and social conversation. Able to read at a normal speed and with almost complete understanding of the text. Will understand most slang.

4 – Advanced professional proficiency. Able to understand extremely difficult forms of speech pertaining to professional needs and social conversations. Nearly native ability to read and understand extremely difficult or abstract prose.

5 – Functionally native proficiency. Can function at the level of a very well educated native (for example, a doctor or lawyer). Able to fully understand all forms of verbal and written speech.

HOW PROFICIENCY OBTAINED

A – Civilian School

B – Defense Language Institute

C – Foreign Residence

D – Home Environment

E – Military School Other Than DLI

F – Self Study

This data is captured into OPMIS & into NSIPS (Navy Standard Integrated Personnel System).

- If the student does not speak a Foreign Language they must place an X in the box listed as “No Self-Assessed Foreign Language Proficiency,” sign and date form.
- Students will list the Foreign languages they know in the language column.
- If the student knows more than four languages, use an additional form.
- If the student speaks a particular dialect of a language, identify the dialect and list each dialect as an individual language (e.g. Arabic-Egyptian, Arabic-Saudi; Chinese-Mandarin, Chinese-Cantonese)
- Many Tagalog speakers also know other regional Philippine dialects. Students will list those as separate languages. Some of the more common examples include: Cebuano, Ilocano, Ilongo, (Ka)Pampangan and Visayan (Bisayan).

Student Signature/Date: Arleigh Burke 6/2/2015

From: Arleigh A. Burke, **CU Student ID:** If known

To: **Commanding Officer, NROTC Unit, University of Colorado**

Subj: **Written Consent for Release of Information**

Date: 6/2/2015

- 1. I authorize the Commanding Officer, Naval ROTC Unit, University of Colorado to display my picture and name, my name and battalion billet, and any other information deemed appropriate in the NROTC office spaces and unit website for the purpose of recognition, group familiarity, and unit cohesion.**

A rectangular box containing a handwritten signature in cursive script that reads "Arleigh A. Burke".

Signature of Student