Electronic Questionnaires for Investigations Processing (e-QIP) Investigation Request #9546559

SIGNATURE FORMS

The signature(s) in this document refer to information on forms submitted in the e-QIP Investigation Request #9546559. The signature on the statement below is as valid as directly signing the same statement on a printed e-QIP Investigation Request #9546559 Official Archival Copy. This signed statement and an image of each page from the e-QIP Investigation Request #9546559 Official Archival Copy will be considered official record.

Sign and submit all forms in this document to the office that initiated your Investigation Request.

Data Hash Code: **ea4fd7b0a67dd97e46aabb359d53fe537321d79d**
Official Archival Copy PDF Hash Code: **8f56f9948d69cec35fef2440ba393e338527f6ed**
Date/Time Certified in the e-QIP System: **2011-02-02 22:09:47.480**
Applicant's Social Security Number: **208-68-1636**

Questionnaire for Public Trust Positions (SF85P Format)

OMB No. 3206-0005

Certification That My Answers Are True

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

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

Standard Form 85P Format
Revised September 1995
United States Office of Personnel Management
5 CFR Parts 731, 732, and 736

Form approved:
OMB No. 3206-0005
NSN 7540-01-317-7372
85-1602

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 security clearance.

I Understand that, for financial or lending institutions, medical institutions, hospitals, health care professionals, and other sources of information, a separate specific release will be needed, and I may be contacted for such a release at a later date. Where a separate release is requested for information relating to mental health treatment or counseling, the release will contain a list of the specific questions, relevant to the job description, which the doctor or therapist will be asked.

I Further Authorize any investigator, special agent, or other duly accredited representative of the U.S. Office of Personnel Management, the Federal Bureau of Investigation, the Department of Defense, the Defense Investigative Service, 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 sensitive 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 85P, and that it may be redisclosed by the Government only as authorized by law.

Copies of this authorization that show my signature are as valid as the original release signed by me. 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.

<table>
<tr><td>Signature (Sign in ink)</td><td colspan="3">Full Name (Type or Print Legibly)
Jason Michael Larkin</td><td>Date Signed (mm/dd/yyyy)</td></tr>
<tr><td colspan="4">Other Names Used</td><td>Social Security Number</td></tr>
<tr><td colspan="2">Current Address (Street, City)
4763 Sherwood Drive, Pittsburgh</td><td>State
PA</td><td>Zip Code
15236</td><td>Home Telephone Number (Include Area Code)
4123988813</td></tr>
</table>

e-QIP Version 2
e-QIP Investigation Request #9546559 **e-QIP Document Type REL**

Standard Form 85P Format
Revised September 1995
United States Office of Personnel Management
5 CFR Parts 731, 732, and 736

Form approved:
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NSN 7540-01-317-7372
85-1602

UNITED STATES OF AMERICA

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

Instructions for Completing this Release

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

I am seeking assignment to or retention in a position of public trust with the Federal Government as a(n)

_____

(Investigator instructed to write in position title.)

As part of the investigative 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:

Does the person under investigation have a condition or treatment that could impair his/her judgment or reliability?

If so, please describe the nature of the condition and the extent and duration of the impairment or treatment.

What is the prognosis?

I understand that the information released pursuant to this release is for use by the Federal Government only for purposes provided in the Standard Form 85P and that it may be redisclosed by the Government only as authorized by law.

Copies of this authorization that show my signature are as valid as the original release signed by me. This authorization is valid for 1 year from the date signed or upon termination of my affiliation with the Federal Government, whichever is sooner.

Signature *(Sign in ink)*	Full Name *(Type or Print Legibly)*		Date Signed *(mm/dd/yyyy)*
	Jason Michael Larkin		
Other Names Used			Social Security Number
Current Address *(Street, City)*	State	Zip Code	Home Telephone Number *(Include Area Code)*
4763 Sherwood Drive, Pittsburgh	PA	15236	4123988813