Date: December 29, 2022

In the matter of:	)	
-----	)	ISCR Case No. 20-01838
Applicant for Security Clearance	)	

APPEAL BOARD DECISION

APPEARANCES

FOR GOVERNMENT
Andrea M. Corrales, Esq., Department Counsel
James B. Norman, Esq., Chief Department Counsel

FOR APPLICANT
Maurice Arcadier, Esq.

The Department of Defense (DoD) declined to grant Applicant a security clearance. On October 30, 2020, DoD issued a statement of reasons (SOR) advising Applicant of the basis for that decision—security concerns raised under Guideline I (Psychological Conditions) of Department of Defense Directive 5220.6 (Jan. 2, 1992, as amended) (Directive). Applicant requested a hearing. On August 22, 2022, after close of the record, Defense Office of Hearings and Appeals (DOHA) Administrative Judge Mark Harvey denied Applicant's request for a security clearance. Applicant appealed pursuant to Directive ¶¶ E3.1.28 and E3.1.30.

The SOR alleged two security concerns: diagnoses in 2011 of Bipolar I Disorder (mixed type), Attention-Deficient/Hyperactivity Disorder (ADHD), Generalized Anxiety Disorder, and Obsessive Compulsive Personality (OCP) traits; and diagnoses in 2020 of Bipolar II Disorder, Depressive Disorder (moderate, recurrent, in partial remission), Generalized Anxiety Disorder, and OCP traits. In responding to the SOR, Applicant admitted both sets of diagnoses and provided mitigating information.

On motion of the Government, the Judge took administrative notice of the Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5) sections on Bipolar I Disorder, Bipolar II Disorder, and Major Depressive Disorder. He found adversely to Applicant on both allegations.

Applicant raised the following issues on appeal: whether Applicant was denied due process; whether the Judge failed to consider all the evidence; whether he misstated the medical facts and diagnoses; and whether he failed to apply the mitigation standards correctly. For the reasons below, we remand.

The Judge's Findings of Fact

Applicant is in his mid-forties and married, with no children. He served in the military from 1996 to 2005 and was honorably discharged. Since that time, Applicant has worked for DoD contractors. He has held a security clearance since 1997, with no evidence of security violations.

In 2004, Applicant experienced the loss of his grandfather and friends. Additionally, he was coping with physical problems and relationship issues. In 2005, he sought help from a general practitioner, was diagnosed with depression and Attention Deficit Disorder (ADD), and was prescribed an anti-depressant. Applicant experienced significant side effects, and a physician advised Applicant to stop taking the medication.

In 2006, Applicant again sought medical help, first from another general practitioner and subsequently from a psychiatrist (Dr. D), who diagnosed him with a Bipolar Disorder. Applicant described episodes of mania, to include sleeping only three hours over a four-day period. He was placed on mood stabilizers and Ritalin. Applicant believed that his mania originated from his reaction to Ritalin, which made him feel "like Superman" and unable to sleep. Decision at 3, citing Tr. at 131. Dr. D described Applicant as honest, candid, and reliable and stated that Applicant does not have a condition or treatment that could impair his judgment or reliability. After Dr. D's retirement in 2008, Applicant saw Dr. E for about nine months, but the record does not include Dr. E's diagnosis.

From 2009 to 2010, Dr. F treated applicant and prescribed Lamictal for Applicant's Bipolar Disorder. Applicant asserted that Dr. F told him that he was unsure of the Bipolar Disorder diagnosis. Nevertheless, Applicant stayed on the course of medication and complied with treatment recommendations. In late 2010, Applicant moved to a different state and stopped seeing Dr. F.

From April 2011 to October 2016, Dr. M, a psychiatrist, treated Applicant. Based on Applicant's mental health history upon presentation, Dr. M diagnosed Applicant with Bipolar I Disorder (mixed type) in remission, ADD (sic), Generalized Anxiety Disorder, Major Depression in remission, and OCP traits. Dr. M prescribed Lamictal for mood stabilization as well as an ADHD medication.

In July 2013, Dr. M changed his diagnosis to Major Depression in remission, ADHD, and OCP traits, and he reduced the Lamictal prescription. Dr. M noted Applicant's judgment was logical and his mood was stable. During Applicant's background investigation, Dr. M advised the

government investigator he was not confident about the Bipolar Disorder diagnosis and the correct diagnosis might be Anxiety, Depression, ADD, and OCP traits.

Applicant followed all prescribed or recommended treatment from April 2011 to October 2014 and from October 2014 to February 2016 (sic). His last treatment with Dr. M was in October 2016. Applicant did not receive any treatment from October 2014 to February 2016, and Dr. M did not remember why Applicant stopped treatment during that timeframe. Dr. M believed Applicant would carefully safeguard classified information because he is a perfectionist, anxious, and has OCD.

Although the medical records in some instances said to see Dr. M every few weeks, Applicant said that Dr. M told Applicant to see him when needed or to renew a prescription. Dr. M never told him to stop taking Lamictal. In 2017, Applicant saw Dr. M's spouse because Dr. M was out of the office. He did not provide the dates when he saw Dr. M's spouse.

In November 2017, Applicant went to Europe, forgot his medications, and discovered he felt better without his medications. Applicant believes he can maintain stable mental health through a low carbohydrate diet and exercise. On the five or six times when he has cheated on his diet, his symptoms of tiredness and lethargy have returned.

The DoD Consolidated Adjudications Facility (CAF) asked Dr. B, a licensed clinical psychologist, to evaluate Applicant for continued access to classified information. In April 2020, Dr. B submitted a psychological report to the DOD CAF in which she considered Applicant's background information, her clinical interview and observations of Applicant, and Applicant's Personality Assessment Inventory (PAI). Dr. B diagnosed Applicant with Bipolar II Disorder, Depressive Disorder (moderate, recurrent, in partial remission), Generalized Anxiety Disorder, and OCP traits. Dr. B explained her diagnoses as follows:

> Applicant's presentation was inconsistent with his psychological test results, as he certainly is quite anxious, ruminative, and possibly hypomanic at this time. His insight is clearly lacking and his fixation on "blood sugar issues" and diet as opposed to voicing awareness of his psychiatric diagnoses is concerning. He describes a history of at least one hypomanic episode that he claims was the result of taking Ritalin as prescribed, although that is highly unlikely. He also describes numerous episodes of depression. Therefore, I find that the prior diagnosis of bipolar disorder is appropriate. It does not seem plausible that he has ADHD in my opinion, as he does not describe his attention as being problematic until adulthood. I suspect his attentional issues are related to his other psychiatric conditions. [Decision at 6, quoting GE 2 at 5–6.]

Dr. B opined that Applicant's prognosis was "poor, based on his limited insight and the absence of ongoing care for psychiatric conditions." *Id.*

Applicant sought an assessment from Dr. S, a licensed clinical social worker with a Ph.D. in psychology. Dr. S saw Applicant regularly since December 2020 and concluded that that Applicant does not meet the criteria for Bipolar Disorder. Dr. S did not review Applicant's past

medical records and was unaware that Applicant experienced symptoms of Bipolar and Major Depressive Disorder for several years. Dr. S based his diagnosis of "almost perfectionistic" on his interview of Applicant, his spouse, and his coworkers. Decision at 7, citing Tr. at 33, 36.

Applicant has not taken any medications for his mental health since November 2017. He does not believe that he has a chronic mental illness or that he requires psychiatric care. He decided not to return to see Dr. M in 2017 after consulting with his spouse who does not have any training in psychology. If problems develop, he would seek help from a mental-health practitioner and is willing to see a provider if it will satisfy security requirements.

Applicant relied upon his facility security officer (FSO) for advice on security matters and said security officials told him the security issue was the Bipolar diagnosis. Consequently, Applicant believed his security issue was resolved when Dr. M changed his diagnosis from Bipolar to Depression. He told his FSO when the issue of his mental health first arose and when he stopped following treatment recommendations and taking his medications. The FSO did not recommend whether he should follow medical advice or tell him that he needed to communicate with his treatment provider about not taking his medications.

When Applicant received the SOR, he did not know what to do. Supervisors suggested he seek an opinion from a third party, so he sought assistance from Dr. S and provided his medical records. Applicant presented three character witnesses at his hearing and 16 written statements from his coworkers, friends, pastor, and wife. The general sense of their statements is that Applicant is friendly, reliable, diligent, professional, responsible, detail oriented, and trustworthy.

The Judge's Analysis

The record establishes Adjudicative Guideline (AG) ¶¶ 28(b) and 28(d).[1]

Turning to the mitigating conditions, there is no evidence that Applicant engaged in any problematic behavior or was hospitalized for a mental-health issue. "He followed all prescribed or recommended treatment from April 2011 to October 2014, from October 2014 to February 2016 (sic), and from January 2020 to present." Decision at 11. However, AG ¶¶ 29(b) and 29(c)[2] do not fully apply. There is no evidence Dr. S was acceptable to and approved by the U.S. Government, and he did not establish he is "a duly qualified mental health professional" as required.

[1] AG ¶ 28(b): an opinion by a duly qualified mental health professional that the individual has a condition that may impair judgment, stability, reliability, or trustworthiness; AG ¶ 28(d): failure to follow a prescribed treatment plan related to a diagnosed psychological/psychiatric condition that may impair judgment, stability, reliability, or trustworthiness, including, but not limited to, failure to take prescribed medication or failure to attend required counseling sessions.

[2] AG ¶ 29(b): the individual has voluntarily entered a counseling or treatment program . . . with a favorable prognosis by a duly qualified mental health professional; AG ¶ 29(c): recent opinion by a duly qualified mental health professional employed by, or acceptable to and approved by, the U.S. Government that an individual's previous condition is under control or in remission, and has a low probability of recurrence or exacerbation.

> After a careful review of the evidence, I believe Dr. M's initial diagnosis and Dr. B's diagnosis and prognosis are the most accurate and reliable diagnoses and prognosis. The record documents a history of multiple depressive episodes and at least one manic episode. Dr. S's diagnosis of "almost perfectionistic" and the resulting prognosis are unreliable because he did not review Applicant's mental-health records, consult with previous treatment providers, or perform psychological testing. . . .
>
> Applicant did not go to any appointments with Dr. M from October 24, 2014, to March 30, 2016, and from 2017 to December 2020. He did not seek mental-health treatment advice before stopping his use of Lamictal. In December 2020, he started seeing Dr. S, who supported his notion that his mental-health problems related to diet, and he did not have bipolar disorder or any other serious mental health disorder. [Decision at 15.]

Discussion

In deciding whether the Judge's rulings or conclusions are erroneous, we will review the decision to determine whether: it does not examine relevant evidence; it fails to articulate a satisfactory explanation for its conclusions, including a rational connection between the facts found and the choice made; it does not consider relevant factors; it reflects a clear error of judgment; it fails to consider an important aspect of the case; it offers an explanation for the decision that runs contrary to the record evidence; or it is so implausible that it cannot be ascribed to a mere difference of opinion. *See, e.g.*, ISCR Case No. 14-02563 at 3-4 (App. Bd. Aug. 28, 2015).

On appeal, Applicant raises the issue of due process and argues that the Judge failed to consider all the record evidence and misstated the medical facts and diagnoses. The essence of Applicant's argument is this: (1) the Judge gave undue weight to the psychological report of Dr. B, which was contradicted by more persuasive evidence of record; and (2) Applicant was misdiagnosed with Bipolar Disorder, instead of depression, and acted responsibly in managing his depression.

Failure to Follow Treatment Recommendations

The Judge concluded the evidence established AG ¶ 28(d)—that Applicant failed to follow a prescribed treatment plan. Decision at 10. The Judge relies significantly on that conclusion in rendering this unfavorable clearance decision. In his mitigation analysis, for example, the Judge cites to the facts that "Applicant did not go to any appointments with Dr. M from October 24, 2014, to March 30, 2016, and from 2017 to December 2020." *Id*. at 15. In his whole-person analysis, the Judge states: "Applicant received mental-health counseling and was prescribed drugs to stabilize his mood from 2005 to 2017. In 2017, he unilaterally decided that he would stop taking prescribed medications and he would stop attending appointments with Dr. M. He did not communicate about these decisions with Dr. M." *Id*. at 16. Based on our review of the Judge's

decision, we conclude that his reliance on AG ¶ 28(d) violated Applicant's due process rights under the Directive. Two related aspects of this issue merit discussion.

First, the SOR did not allege that Applicant failed to follow a prescribed treatment plan. Directive ¶ 4.3.1 provides that a final unfavorable clearance decision shall not be made without first providing the applicant with "[n]otice of the specific reasons for the proposed action." In this regard, the Appeal Board has previously stated, when a Judge bases an unfavorable clearance decision on non-alleged conduct or matters, an applicant is denied due process. *See, e.g.*, ISCR Case No. 12-11375 at 5-6 (App. Bd. Jun. 17, 2016). Given the Judge's focus on Applicant's noncompliance with a treatment plan, we conclude that the SOR did not provide Applicant adequate notice that he needed to be prepared to address that specific issue.

Second, the Judge's analysis of Applicant's purported failure to follow the treatment plan focused on a non-alleged mental health condition. In his analysis, the Judge noted, "Applicant did not go to any appointments with Dr. M from October 24, 2014 to March 30, 2016 and from 2017 to December 2020." Decision at 15. During that entire period, Applicant was only diagnosed with Major Depression in Remission, ADHD, and OCP traits.[3] Regarding Applicant's purported noncompliance with the treatment plan, it appears that Applicant's depression was the main mental health condition of concern even though it was in remission. At the hearing, Applicant was questioned extensively about his depression. Additionally, the Judge took administrative notice of Major Depression Disorder, quoting at length provisions from DSM-5 regarding that disorder. Regarding this issue, it merits noting that SOR ¶ 1.a is the only allegation upon which the issue of noncompliance with the treatment plan could be based,[4] and that allegation does not allege that Applicant was diagnosed with any form of depression. Again, Applicant had no notice that the Judge would focus on his non-alleged depression diagnosis in relation to his non-alleged failure to follow a prescribed treatment plan.

In short, because Applicant was not given adequate notice of some specific reasons upon which his unfavorable decision would be based, he was denied the due process afforded him under the Directive.

[3] Of note, on the day that Applicant completed his security clearance application (SCA), the Director of National Intelligence (DNI) issued a memorandum revising the pertinent SCA mental health questions. *See* DNI Memorandum on Revisions to the Psychological and Emotional Health Questions on the Standard Form 86, Questionnaire for National Security Positions, dated November 16, 2016. Under this revision, the pertinent question requires applicants to disclose only if they ever have been diagnosed with Psychotic Disorder, Schizophrenia, Schizoaffective Disorder, Delusional Disorder, Bipolar Disorder, Borderline Personality Disorder, or Antisocial Personality Disorder. Interestingly, had Applicant completed the revised SCA, he would have been required to disclose his former diagnosis of Bipolar Disorder but not his most recent diagnoses of Major Depression, ADHD, or OCP traits. Moreover, in the revised SCA, a failure to follow a treatment plan for depression is not required to be reported.

[4] The other SOR allegation (SOR ¶ 1.b) pertains to Dr. B's diagnosis and does not involve any treatment plan. In conducting a DoD-requested psychological examination, Dr. B is not a "treating" mental health care professional and prescribed no treatment plan. Additionally, Applicant first became aware of Dr. B's diagnosis when he received the SOR. SOR Response. Said differently, Dr. B's diagnosis of Depressive Disorder (moderate, recurrent, in partial remission) cannot serve as a basis for claiming Applicant failed to follow a treatment plan.

Dr. B's Report and Dr. M's Initial Diagnosis

As Applicant contends, the Judge relied heavily on Dr. B's report in arriving at his adverse determination under AG ¶ 28(b). In his whole-person analysis, the Judge concludes that "Dr. B's diagnosis and prognosis are given greater weight than the other diagnoses and prognoses of record." Decision at 16. In his Guideline I analysis, the Judge concludes that "Dr. M's **initial** diagnosis and Dr. B's diagnosis and prognosis are the most accurate and reliable diagnoses and prognosis." *Id*. at 15 (emphasis added). Applicant persuasively argues the Judge failed to articulate a satisfactory explanation for these conclusions.

Applicant testified that his psychological evaluation with Dr. B initially started as a Zoom video call, but "when we first started we were having technical difficulties" and conducted the interview over the "regular phone" for an hour. Tr. at 101. Regarding Dr. B's report, the Judge found that "Dr. B provided a detailed mental-health history of Applicant." Decision at 6. However, a review of Dr. B's report confirms Applicant's assertion that Dr. B "failed to see" or "missed" the medical records from Applicant's five years of treatment with Dr. M. Appeal Brief at 1 and 9. In her "detailed" summary of Applicant's mental health history, Dr. B refers only one time to Dr. M. That reference is to the investigator's interview of Dr. M, conducted in February 2019. She makes no reference to the psychiatrist's medical records over the course of five years, which include the following critical details regarding Applicant's mental health:

1. Although Dr. M initially diagnosed Applicant with, *inter alia*, Bipolar Disorder I, mixed type, in April 2011, he promptly changed his diagnosis the following month to "Bipolar Disorder I, mixed type, in Remission."

2. In June 2012, Dr. M removed Applicant's diagnosis of Generalized Anxiety Disorder.

3. In July 2013, Dr. M affirmatively changed the diagnosis of Bipolar Disorder I in Remission to Major Depression in Remission. That change in diagnosis required the psychiatrist to determine that "[t]here has never been a manic episode or a hypomanic episode." DSM-5 at 160-161.

4. This affirmative change in diagnosis was made by a psychiatrist after twenty-seven months of continuous, regular treatment of Applicant.

5. In January 2014, Dr. M reduced Applicant's daily dosage of mood-stabilizing medications to a third of his initial dosage.

6. Through October 2016, the last in-person session with Dr. M of record, Dr. M maintained his diagnosis of Major Depression in Remission. Through November 2017, when Applicant departed for Europe, he remained on the reduced medication regimen prescribed by Dr. M.

Because Dr. B omitted any discussion of Dr. M's medical records and the change in diagnosis, she never addressed (1) why her diagnosis differed so dramatically from his; and (2) how she was better positioned to diagnose Applicant following a one-hour phone interview in

comparison to Dr. M's in-person sessions with Applicant over five years. Dr. B's omission of the treating psychiatrist's medical records calls into question the validity and value of her report.

Additionally, as Applicant argues, Dr. B's interpretation of the PAI she administered detracts from the validity of her report. Applicant's PAI revealed an "unremarkable" clinical profile, "with no clinical scale elevations whatsoever," an apparently favorable result. GE 2 at 5. Dr. B however interpreted this result negatively, opining that it demonstrated Applicant "lacks insight into his thoughts behaviors (sic)." She then cited to this "limited insight" in concluding that Applicant had a poor prognosis. GE 2 at 5 and 6. Applicant persuasively contends that "[w]ithout any observation, evidence or articulated facts, Dr. B concluded that [Applicant] was in denial as to his condition." Appeal Brief at 2. We agree that Dr. B's conclusion that a positive PAI test result should be considered a negative result is perplexing, particularly in light of the fact that two psychiatrist (Dr. D and Dr. M) who treated Applicant over a number of years previously concluded his mental health conditions did not raise concerns about his reliability.

Similarly, without adequate explanation, the Judge concludes that Dr. M's initial diagnosis of April 2011 of Bipolar I, mixed type, is more "accurate and reliable" than that same physician's later, corrected diagnosis of Major Depression, in Remission. Decision at 15. This conclusion by the Judge is also puzzling. Dr. M's diagnosis of April 2011 was made during Applicant's intake interview. Just one month later, Dr. M changed the diagnosis to "In Remission." After 27 months of treatment, Dr. M changed the diagnosis to Major Depression in Remission. The Judge fails to explain his conclusion that a diagnosis that Dr. M made during an initial session is more "accurate and reliable" than a diagnosis by the same psychiatrist made after 27 months of sessions and that continued to be maintained for the 3-4 years while Applicant remained under his treatment.

In reaching his conclusion that AG ¶ 28(b) was established, the Judge erred by failing to consider these relevant factors and by failing to articulate a satisfactory explanation.

Dr. S's Testimony

When Applicant received his SOR in November 2020, he became aware of Dr. B's diagnosis of Bipolar II Disorder, as alleged in SOR ¶ 1.b. Answer to SOR at 1. He discussed the SOR with his immediate supervisor and senior management. In the course of those discussions, someone suggested he obtain a third party evaluation (*i.e.*, other than Dr. M and Dr. B) and recommended Dr. S. Tr. at 123–124. Dr. S is a licensed clinical social worker (LCSW) who also holds a Ph.D. in psychology. He has been in private practice as a LCSW since 1990. *Id*. at 26-27. Applicant began seeing Dr. S in December 2020 and continued to see him up to the hearing. Dr. S opined that Applicant does not have Bipolar Disorder or any other mental health conditions other than being a "perfectionist." *Id*. at 35.

In evaluating whether AG ¶ 29(b) or ¶ 29(c) mitigated the alleged security concerns, the Judge discounted Dr. S's testimony and opinion. In concluding those mitigating conditions did not apply, the Judge stated, "there is no evidence Dr. S was acceptable to and approved by the U.S. Government, and he did not establish he is 'a duly qualified mental health professional.'" Decision at 11. We agree with the Judge's determination regarding AG ¶ 29(c) because there no evidence that Dr. S was acceptable to the U.S. Government, as required by that mitigating condition. *See*

Directive, Encl. 2, App. A. ¶ 29(c). However, we are puzzled by his determination regarding AG ¶ 29(b), which provides, "the individual has voluntarily entered a counseling or treatment program for a condition that is amenable to treatment, and the individual is currently receiving counseling or treatment with a favorable prognosis by a duly qualified mental health professional." *Id*. at ¶ 29(b). We note that, with the exception of the Judge's determination regarding Dr. S's professional qualifications, the record evidence tends to support the application of AG ¶ 29(b).

The Judge's determination that Dr. S was not established as a duly qualified mental health professional is followed by the following statements:

> Dr. S did not review Applicant's medical records and showed little interest in his mental health history. His diagnosis of "almost perfectionistic" was inconsistent with the other diagnoses of multiple mental health experts who treated Applicant from 2005 to 2017. [Decision at 11.]

Regarding the first sentence of the apparent justification for the Judge's unfavorable conclusion regarding Dr. S's professional qualifications, we see no significant difference between Dr. S's and Dr. B's review of Applicant's medical records and mental health history. As discussed previously, Dr. B did not address Dr. M's medical records. As to the second sentence, Dr. M, who treated Applicant from 2011 to 2016, reportedly told an investigator that Applicant's Obsessive Compulsive Disorder and anxiety cause him to be highly organized and a "perfectionist." AE L at 46. Furthermore, Dr. S's opinion that Applicant did not meet the criteria for Bipolar Disorder is consistent with Dr. M's latest diagnosis that did not list that disorder. In fact, Dr. M's latest diagnosis appears to align more with Dr. S's diagnosis than Dr. B's. Of note, Dr. B is the only mental health professional who specifically diagnosed Applicant with Bipolar II Disorder, and she contradicts Dr. M's diagnosis by concluding Applicant's ADHD diagnosis "does not seem plausible[.]" Government Exhibit 2 at 5. Based on our review, we conclude that the Judge erred in failing to articulate a satisfactory explanation for concluding that Dr. S, a licensed clinical social worker for over 30 years, was not a duly qualified mental health professional under Guideline I.[5]

Conclusion

The errors identified above warrant a remand. Given the Judge's expressed firm opinions about Applicant's mitigating evidence, we conclude that the best resolution is to remand this case to a different judge for a new hearing. Under Directive E3.1.35, the Judge assigned the case is required to issue a new clearance decision. The Board retains no jurisdiction over a remanded

[5] *The Concern* paragraph (AG ¶ 27) of Guideline I only references clinical psychologists and psychiatrists as examples of duly qualified mental health professionals employed by, or acceptable to, and approved by the U.S. Government, who should be consulted when evaluating potentially disqualifying and mitigating information under this guideline and a opinion prognosis is warranted. However, we do not interpret that paragraph as setting forth an exclusive list of duly qualified mental health professionals when applying the Guideline I disqualifying and mitigating conditions. Of note, Guidelines G and H list licensed clinical social workers as an example of a duly qualified medical and mental health professional. Furthermore, the pertinent revised Section 21 SCA question referenced in note 3, above, provides that an applicant must disclose if he or she has "EVER been diagnosed by a physician or other health professional (for example, a psychiatrist, psychologist, licensed clinical social worker, or nurse practitioner)" with one of the identified mental health disorders. Absent an adequate explanation to the contrary, a state licensed clinical social worker is a duly qualified mental health professional under Guideline I.

decision. However, the Judge's decision issued after remand may be appealed pursuant to Directive ¶¶ E3.1.28 and E3.1.30.

Order

The decision is **REMANDED**.

Signed: James F. Duffy
James F. Duffy
Administrative Judge
Chairperson, Appeal Board

Signed: James E. Moody
James E. Moody
Administrative Judge
Member, Appeal Board

Signed: Moira Modzelewski
Moira Modzelewski
Administrative Judge
Member, Appeal Board