

# Ohio Parole Board Application for Executive Clemency

1. APPLICANT'S NAME: \_\_\_\_\_ ALIAS: \_\_\_\_\_

2. IF Confined:

INSTITUTION:	INSTITUTION NUMBER:	DATE ADMITTED:
PAROLE/PRC ELIGIBILITY DATE:		EXPIRATION OF DEFINITE SENTENCE:
IF PREVIOUSLY INCARCERATED, LIST INSTITUTION NUMBER:		

3. IF NOT Confined:

ADDRESS:	STREET	CITY	STATE	ZIP
DATE RELEASED ON PAROLE/PRC:			FINAL RELEASE DATE:	
DATE GRANTED COMMUNITY CONTROL/PROBATION:			DATE COMMUNITY CONTROL/PROBATION COMPLETED:	

**OR**

4.

DATE OF BIRTH:	AGE:	SOCIAL SECURITY NUMBER:
TELEPHONE #:	CELL PHONE #:	EMAIL:

5. TYPE OF CLEMENCY REQUESTED (SELECT ONE):     Pardon     Commutation     Reprieve

6. HAVE YOU APPLIED FOR CLEMENCY IN THE PAST?     YES     NO - If yes, when: \_\_\_\_\_

7. ARREST RECORD:

COUNTY (CITY)	CASE NO.	CRIME	DATE CONVICTED	SENTENCE	REQUESTING CLEMENCY
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

8. IDENTIFICATION and SUPERVISION STATUS:

What type of ID do you have: <input type="checkbox"/> Driver's License <input type="checkbox"/> None <input checked="" type="checkbox"/> State ID Card	What is the ID Number: _____
What state issued you your driver's license: _____	What is the status of your driver's license: <input type="checkbox"/> Valid <input type="checkbox"/> Expired <input type="checkbox"/> Not Applicable <input checked="" type="checkbox"/> Suspended <input type="checkbox"/> Failure to Reinstate <input type="checkbox"/> Other: _____

Are you currently under any type of supervision:	<input type="checkbox"/> Yes, if yes, specify type of supervision: <input type="checkbox"/> No	<input type="checkbox"/> Pretrial Supervision <input type="checkbox"/> Parole/PRC	<input type="checkbox"/> Probation Community Control
Supervising Officer's Name:	Location/Court:	Supervising Office's Phone #:	
Do you have any outstanding charges pending and/or protection orders against you, If yes, where?			

**9. Social History**

**Marital**

Marital status at the time the offense was committed:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Current Marital status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed

**Current Spouse/Domestic Partner:**

Name: <i>(last, first, middle)</i>
Address: <i>(street, city, state, zip code and county)</i>
Has your current spouse/domestic partner ever been convicted of any crimes: <input type="checkbox"/> Yes <input type="checkbox"/> No

**Previous Spouse(s)/Domestic Partner(s):**

Name: <i>(last, first, middle)</i>	Date of Marriage:	Date of Divorce/Separation/Widowed:
Address: <i>(street, city, state, zip code and county)</i>		
Has this previous spouse/domestic partner ever been convicted of any crimes: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Name: <i>(last, first, middle)</i>	Date of Marriage:	Date of Divorce/Separation/Widowed:
Address: <i>(street, city, state, zip code and county)</i>		
Has this previous spouse/domestic partner ever been convicted of any crimes: <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Children:** *If you have more than six (6) children, please use the bottom of the next page and answer the same questions.*

Child's Name: <i>(last, first)</i>	Age/DOB:			
Address: <i>(street, city, state, zip code and county)</i>				
Other Parent's Name: <i>(last, first)</i>				
Do you have custody: <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, what is the Name and Relation of the person who has custody of the child: <i>(e.g., grandmother, aunt, god-parent)</i>			
Are you ordered to pay support: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which county:	Amount per month:	Arrearage:	Date of Last Payment:

**Children:** *If you have more than six (6) children, please use the bottom of the next page and answer the same questions.*

. Child's Name: <i>(last, first)</i>		Age/DOB:	
Address: <i>(street, city, state, zip code and county)</i>			
Other Parent's Name: <i>(last, first)</i>			
Do you have custody: <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, what is the Name and Relation of the person who has custody of the child: <i>(e.g., grandmother, aunt, god-parent)</i>	
Are you ordered to pay support: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, which county:	Amount per month:
		Arrearage:	Date of Last Payment:

**Children:** *If you have more than six (6) children, please use the bottom of the next page and answer the same questions.*

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Address: <i>(street, city, state, zip code and county)</i>			
Other Parent's Name: <i>(last, first)</i>			
Do you have custody: <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, what is the Name and Relation of the person who has custody of the child: <i>(e.g., grandmother, aunt, god-parent)</i>	
Are you ordered to pay support: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, which county:	Amount per month:
		Arrearage:	Date of Last Payment:

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Address: <i>(street, city, state, zip code and county)</i>			
Other Parent's Name: <i>(last, first)</i>			
Do you have custody: <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, what is the Name and Relation of the person who has custody of the child: <i>(e.g., grandmother, aunt, god-parent)</i>	
Are you ordered to pay support: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, which county:	Amount per month:
		Arrearage:	Date of Last Payment:

**Children:** *If you have more than six (6) children, please use the bottom of the next page and answer the same questions.*

. Child's Name: <i>(last, first)</i>		Age/DOB:	
Address: <i>(street, city, state, zip code and county)</i>			
Other Parent's Name: <i>(last, first)</i>			
Do you have custody: <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, what is the Name and Relation of the person who has custody of the child: <i>(e.g., grandmother, aunt, god-parent)</i>	
Are you ordered to pay support: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, which county:	Amount per month:
		Arrearage:	Date of Last Payment:

**Children:** *If you have more than six (6) children, please use the bottom of the next page and answer the same questions.*

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Address: <i>(street, city, state, zip code and county)</i>			
Other Parent's Name: <i>(last, first)</i>			
Do you have custody: <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, what is the Name and Relation of the person who has custody of the child: <i>(e.g., grandmother, aunt, god-parent)</i>	
Are you ordered to pay support: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, which county:	Amount per month:
		Arrearage:	Date of Last Payment:

## Associations

Are you now, or have you ever been, a gang member: <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, what was/is the name of the gang:	
What was your rank in the gang:	How many years have you been or were you a gang member: Years
List any other social groups or organizations of which you are a member (e.g., church, sport team, Kiwanis, Masons, etc.)	

## Residence

With whom were you living at the time the crime was committed:				
<input type="checkbox"/> Alone	<input type="checkbox"/> With Parent(s)	<input type="checkbox"/> With Children(s)	<input type="checkbox"/> With Grandparents	<input type="checkbox"/> With Spouse/Domestic Partner
<input type="checkbox"/> With Spouse/Domestic Partner & Children		<input type="checkbox"/> Other (specify):		
With whom are you currently living:				
<input type="checkbox"/> Alone	<input type="checkbox"/> With Parent(s)	<input type="checkbox"/> With Children(s)	<input type="checkbox"/> With Grandparents	<input type="checkbox"/> With Spouse/Domestic Partner
<input type="checkbox"/> With Spouse/Domestic Partner & Children		<input type="checkbox"/> Other (specify):		
Type of Residence:				
<input type="checkbox"/> Homeless	<input type="checkbox"/> House	<input type="checkbox"/> Trailer	<input type="checkbox"/> Apartment	<input type="checkbox"/> Room
<input type="checkbox"/> Other (specify):				
Type of Costs:				
<input type="checkbox"/> Own/Mortgage	<input type="checkbox"/> Rent	<input type="checkbox"/> No Cost	<input type="checkbox"/> Subsidized	
<input type="checkbox"/> Other (specify):				

Individuals living with you at your **current** address:

<b>Name:</b>	Last	First	Age:	Relationship: <i>(step-son, spouse, etc.)</i>
<b>Name:</b>	Last	First	Age:	Relationship: <i>(step-son, spouse, etc.)</i>
<b>Name:</b>	Last	First	Age:	Relationship: <i>(step-son, spouse, etc.)</i>
<b>Name:</b>	Last	First	Age:	Relationship: <i>(step-son, spouse, etc.)</i>

Names of other cities, states or countries in which you have lived:
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## Education:

Highest grade completed:	<input type="checkbox"/> V <input type="checkbox"/>	Year:	GED:	<input type="checkbox"/> Yes, year - <input type="checkbox"/> Working on it	<input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> V <input type="checkbox"/>
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If, non-HS Graduate Reason for Leaving	(High School/Post H.S.) Last School(s) Attended	Location	
		City	State

List any learning difficulties or problems (e.g. special education, suspension, expelled) you had in school:

List any Licenses/Certifications/Vocational & Technical Certificates:

List any Special Skills Training you have had (e.g., martial arts, weapons):

### Military History

Branch			
<input type="checkbox"/> None (Skip to Physical Health)	<input type="checkbox"/> National Guard (Army)	<input type="checkbox"/> National Guard (Air Force)	<input type="checkbox"/> Reserves (any branch)
<input type="checkbox"/> Navy	<input type="checkbox"/> Army	<input type="checkbox"/> Air Force	<input type="checkbox"/> Marines
<input type="checkbox"/> Coast Guard	<input type="checkbox"/> Other (specify):		

Type of Discharge		
<input type="checkbox"/> Uncharacterized	<input type="checkbox"/> Conditions other than Honorable	<input type="checkbox"/> Bad Conduct
<input type="checkbox"/> Entry Level Separation	<input type="checkbox"/> Undesirable	<input type="checkbox"/> Dishonorable
<input type="checkbox"/> General Under Honorable Conditions	<input type="checkbox"/> Other (specify):	

Admission Date:	Discharge Date:	Highest Rank:	Are you receiving benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No
Disciplinary/Special Training/Additional Comments:			Military History <input type="checkbox"/> V

**Physical Health -** Current Status:  Good  Fair  Poor  Disabled

### Substance Abuse

Substance	How Often & How Much Used			Method(s) of Use		Age 1st Used	Date Last Used	Use at time of Offense	
	• Less than 12 times/yr	• 2 times/wk		• Oral	• Inhale			Yes	No
	• Once a month	• 3 times/wk or more		• Inject/Intravenous	• Snort				
• Twice a month	• Daily	• Binge	• Inject/Subcutaneous	• Smoke					
• Once/wk	Past	Current	Heaviest Use	• Other (specify):					
Alcohol								<input type="checkbox"/>	<input type="checkbox"/>
Amphetamine								<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates								<input type="checkbox"/>	<input type="checkbox"/>
Marijuana								<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy								<input type="checkbox"/>	<input type="checkbox"/>
LSD								<input type="checkbox"/>	<input type="checkbox"/>
Prescription								<input type="checkbox"/>	<input type="checkbox"/>
Crack Cocaine								<input type="checkbox"/>	<input type="checkbox"/>
Powder Cocaine								<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine								<input type="checkbox"/>	<input type="checkbox"/>
Heroin								<input type="checkbox"/>	<input type="checkbox"/>
Inhalants								<input type="checkbox"/>	<input type="checkbox"/>
Opiates								<input type="checkbox"/>	<input type="checkbox"/>
None								<input type="checkbox"/>	<input type="checkbox"/>
Other:								<input type="checkbox"/>	<input type="checkbox"/>

### Substance Abuse Treatment

Facility/Program: <input type="checkbox"/> <input type="checkbox"/>				Was treatment court ordered: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Location:					
Type of Treatment: <input type="checkbox"/> Out-Patient		<input type="checkbox"/> In-Patient		<input type="checkbox"/> CBCF	
<input type="checkbox"/> Intensive Out-Patient		<input type="checkbox"/> Halfway House		<input type="checkbox"/> Other (specify):	
Treatment for:	Date Started:	Date Ended:	Successfully Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>		

Facility/Program: <input type="checkbox"/> <input type="checkbox"/>				Was treatment court ordered: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Location:					
Type of Treatment: <input type="checkbox"/> Out-Patient		<input type="checkbox"/> In-Patient		<input type="checkbox"/> CBCF	
<input type="checkbox"/> Intensive Out-Patient		<input type="checkbox"/> Halfway House		<input type="checkbox"/> Other (specify):	
Treatment for:	Date Started:	Date Ended:	Successfully Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>		

Have you been involved with any other case managers/case workers at any other social service agencies (e.g., Children's Services, Veteran's Administration)?		
<input type="checkbox"/> Yes (if yes, please identify the date(s) of service, agency & address below)		
Date Started:	Date Ended:	Agency: (also name of case manager)
Agency Address: (address,city,state)		

Facility/Program:	v <input type="checkbox"/>	Was treatment court ordered:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Location:				
Type of Treatment:	<input type="checkbox"/> Out-Patient	<input type="checkbox"/> In-Patient	<input type="checkbox"/> CBCF	
	<input type="checkbox"/> Intensive Out-Patient	<input type="checkbox"/> Halfway House	<input type="checkbox"/> Other (specify):	
Treatment for:	Date Started:	Date Ended:	Successfully Completed:	v <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>

**Current Situation:**

Do you currently have a substance abuse problem?  Yes  No

Do you want further substance abuse treatment?  Yes  No

**10. Employment**

Employment Status at Time of Offense		Current Employment Status		Reason Not Employed	
<input type="checkbox"/> Full-Time	<input type="checkbox"/> Temporary Agency	<input type="checkbox"/> Full-Time	<input type="checkbox"/> Temporary Agency	<input type="checkbox"/> Homemaker	<input type="checkbox"/> Laid-Off
<input type="checkbox"/> Part-Time	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Part-Time	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Student	<input type="checkbox"/> Incarcerated
<input type="checkbox"/> Self-Employed	<input type="checkbox"/> Under the Table	<input type="checkbox"/> Self-Employed	<input type="checkbox"/> Under the Table	<input type="checkbox"/> Retired	<input type="checkbox"/> Limited Skills/ Training
<input type="checkbox"/> Seasonal	<input type="checkbox"/> Never Worked	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Never Worked	<input type="checkbox"/> Disabled	
<input type="checkbox"/> Other (specify below):	<input type="checkbox"/> Laid-Off	<input type="checkbox"/> Other (specify below):	<input type="checkbox"/> Laid-Off	<input type="checkbox"/> Other (specify):	

**Employment History**

Employer <i>List Most Recent/Current Employer first: (name, address)</i>	Job Title	Start Date	End Date	Hourly Wage	Avg. Hours per Week	Reason for Leaving <i>(e.g., quit, fired, disabled, lay-off, incarcerated, etc.)</i>
v <input type="checkbox"/>					v <input type="checkbox"/>	
<input type="checkbox"/>					<input type="checkbox"/>	
<input type="checkbox"/>					<input type="checkbox"/>	
<input type="checkbox"/>					<input type="checkbox"/>	
<input type="checkbox"/>					<input type="checkbox"/>	

**Current/Most Recent Employer Contact Information:**

Employee Address (street, city, state and zip code):	
Supervisor:	Phone (including area code):

**11. Offense**

Describe in your own words your crime or offense. Include any reason you had for committing the crime or offense and how you feel about what you did.

List the First and Last Name of the People who were also Involved in Your Offense:

12. COMMUNITY/VOLUNTEER SERVICE: (SEE INSTRUCTIONS)

13. NEED FOR CLEMENCY:

- EMPLOYMENT OPPORTUNITIES
- LICENSING/BOARD EXAMS/PUBLIC OFFICE
- VOLUNTEER OPPORTUNITIES
- DEPORTATION
- DISPARATE SENTENCE
- MEDICAL
- OTHER:

14. ATTACHMENTS: (LETTERS IN SUPPORT, COURT PAPERS, DIPLOMAS, ETC.) (SEE INSTRUCTIONS)

*I HEREBY SWEAR THAT THE INFORMATION CONTAINED IN THIS APPLICATION AND THE ATTACHED DOCUMENTS IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:*

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE

IF PREPARED BY ATTORNEY:

\_\_\_\_\_  
ATTORNEY'S NAME

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
ATTORNEY'S SIGNATURE

\_\_\_\_\_  
DATE

*\* The application, along with the attachments will be provided to the sentencing court and/or prosecuting attorney's office in the county of conviction, if requested.*





## Clemency Request for Information

The person identified below has applied for Clemency through the Ohio Parole Board. The information requested is needed to assist the Adult Parole Authority in preparing a written investigation regarding this individual. Your cooperation will be greatly appreciated. Please return this form with the requested information within three (3) days.

**Addressee:**

Date:
Requesting Person/Unit (If Applicable):

Name (last, first, middle):		Maiden Name or Alias:	
Date of Birth:	Social Security Number:	FBI Number:	BCI Number:
Sex:	Race:	Inmate Number:	CCIS Number:

### Information Desired (please elaborate and give additional comments)

- Sealed/Expunged Record** Any information in your possession or control pertaining to prior conviction or criminal record that is under seal or order for expungement
- Prior Arrest Record** Dates, Charges, Dispositions, Offenses involving **Weapons or Violence**, please provide arrest report(s)
- Educational Data** Grade Completed, General Rating as a Student, Mental or Intelligence Examination Results, Attendance, Reason Left, Comments, Copy of Transcripts
- Employment Data** Confirmation of Employment, Dates, Position(s) Held, Wages, Reason for Termination, Consideration for Re-employment, and Comments
- Substance Abuse** Chemical or Alcohol Addiction, Treatment,
- Medical History** Recommendations, Diagnoses of Physical/Mental Ailments and/or Disabilities, Current Drug Prescriptions, Treatments, HIV/STD Status and Treatment, Discharge Summary, Hospitalizations and Recommendations
- Mental Health History** Mental Health Assessment, Diagnosis, Treatment, Discharge Summary, Recommendations
- Military Service** Dates of Service, Branch, Discharge Type, Rank Attained, Court Martial (type, nature of offense, dates, and sentence)
- Other** (Specify): \_\_\_\_\_

I authorize release to the Ohio Parole Board all confidential records and information concerning me, this includes: criminal, traffic, vocational, educational, employment, military, medical, including HIV, mental health, drug and alcohol abuse treatment records and any other requested information. I understand that the Parole Board may share this information with other entities to facilitate the clemency request. This consent will remain valid throughout the duration of the clemency process with the Ohio Parole Board. A copy of this authorization made by duplicating process shall be considered the same as the original signed one.

If my record has been sealed or expunged, I authorize the Ohio Bureau of Criminal Investigation and/or my sentencing court to release any information in its possession or control pertaining to my prior conviction or criminal record, that is currently under seal or order for expungement to the Ohio Parole Board for consideration of my application for clemency.

Applicant Signature:	Date:
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Please stamp **NO RECORD FOUND** here or attach information to back of form and return to the address above.

Signature of Official Sending the Information:	Title:	Date
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Revised Code prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or \*Notice: This request includes records protected by federal confidentiality rules (42 CFR, Part 2). The federal rules and Section 5122.31 and/or Section 3701.243 of the Ohio as otherwise permitted by 42 CFR, Part 2. A general authorization for release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

If additional space is required use reverse side