

10. List any other professional certifications you hold or held (e.g. CRNA, CAC, etc...)?
- State: _____ Type: _____ Certification #: _____
- State: _____ Type: _____ Certification #: _____
11. Professional specialty (If any: e.g. anesthesiology, critical care, etc...):
12. Has any action been taken against you by any licensing and/or certification board, or is any such action pending? (If yes, provide details. Attach additional sheets if necessary):

EMPLOYMENT SECTION:

13. Are you currently employed? _____ Yes _____ No
- Name of employer: _____
- Address: _____
- _____
- Name of supervisor: _____
- Phone: _____ Date of hire: _____
- Is your employer aware you contacted the PHMP? _____ Yes _____ No
14. List all places you have been employed in the past three years.
- a) Name of employer: _____
- Address: _____
- Name of supervisor: _____
- Phone: _____ Dates of employment: _____
- b) Name of employer: _____
- Address: _____
- Name of supervisor: _____
- Phone: _____ Dates of employment: _____

Please attach extra sheets if you had additional employers in the past three years.

LEGAL SECTION:

- 15. Do you currently have any criminal charges filed against you or is any action pending in any court or jurisdiction? (If yes, provide details. Attach additional sheets if necessary):

- 16. Have you ever been convicted, found guilty, or pleaded guilty or no contest, or received probation without verdict or accelerated rehabilitation disposition (ARD) as to any felony or misdemeanor, including drug law violations or driving under the influence (DUI)? (If yes, provide details. Attach additional sheets if necessary):

HEALTH CARE/MEDICAL SECTION:

- 17. Nature of problem: (Please check all appropriate categories):
 Alcohol Other Drug Mental Health Physical
Specify all chronic conditions (e.g. diabetes, hypertension, etc...): _____

Are you currently being treated for any of the problems listed above? Yes No

- 18. Name of your primary health care practitioner: _____
Address: _____
Phone #: _____

- 19. List **ALL** medications you are currently taking, the name of the prescribing practitioner, and the condition or illness. (Attach additional sheets if necessary):

Medication	Prescriber	Illness/Condition
Medication	Prescriber	Illness/Condition
Medication	Prescriber	Illness/Condition
Medication	Prescriber	Illness/Condition
Medication	Prescriber	Illness/Condition

PHMP-APPROVED EVALUATION SECTION:

20. Name of your PHMP-approved evaluator: _____
21. Date of your PHMP-approved evaluation: _____

SUBSTANCE USE SECTION:

22. Are you suffering from or have you previously been diagnosed as suffering from a substance use disorder? _____Yes _____No

If yes, complete #23 – #26.

23. I acknowledge that the following facts are true:

I suffer from: _____
(Specify type of substance use disorder)

which I began to develop approximately: _____
(Date)

24. The following represents a brief history of the course and symptoms of my substance use disorder:

a. My drug/alcohol use began (include age(s) and duration):

b. Specific drug(s) used/abused (e.g. percocet, vicodin, cocaine, alcohol, etc...):

c. How drugs were obtained:

- d. Reason(s) for use:
- e. Amount/time/place/pattern of use (describe progression of the illness; for example: "used between 5 and 10 percocet daily, diverted from work, both on and off the job; also drank 1-2 six packs of beer a night, for three years; progressed to 10 percocet and one pint blended whiskey daily for six months.")
- f. Date of last use of any drug(s) of abuse (including alcohol):
- g. List any consequences you suffered as a result of your substance use disorder: (e.g. accidents; overdoses; hospitalizations; treatment; arrests; decline in work performance; employment problems; family/relationship problems; etc).

DRUG & ALCOHOL TREATMENT:

25. Name of current treatment program/provider: _____

Address: _____

Telephone #: _____

Date treatment began: _____ ended: _____

Name of aftercare/continuing care counselor: _____

Address: _____

Telephone #: _____

Date treatment began: _____ ended: _____

26. Have you ever received drug and alcohol treatment in the past? _____ Yes _____ No

a. Name of treatment program/provider: _____

Address: _____

Telephone #: _____

Date treatment began: _____ ended: _____

Reason for treatment: _____

b. Name of treatment program/provider: _____

Address: _____

Telephone #: _____

Date treatment began: _____ ended: _____

Reason for treatment: _____

If additional providers, please attach extra sheets if necessary

MENTAL HEALTH SECTION:

27. Have you been diagnosed as suffering from a mental health disorder?
_____ Yes _____ No

If yes: complete #28 – #33.

28. I acknowledge that the following facts are true:

I suffer from: _____
(Specify type of mental health disorder)

which I began to develop approximately: _____
(Date)

29. Are you currently or have you ever been treated for a mental health disorder (e.g. Depression, Bipolar Disorder, Anxiety, PTSD, Personality Disorder, etc...)?

_____ Yes _____ No

Specify mental health disorders: _____

a. Name of treatment provider: _____

Address: _____

Telephone #: _____

Date treatment began: _____ ended: _____

Reason for treatment: _____

b. Name of treatment provider: _____

Address: _____

Telephone #: _____

Date treatment began: _____ ended: _____

If additional providers, please attach extra sheets if necessary

- c. List any medications prescribed for this illness (please provide name of medication, dosage, and number of times a day taken):

30. Have you ever required hospitalization for treatment of a mental health disorder?

_____ Yes _____ No

a. Name of facility: _____

Address: _____

Telephone #: _____

Date treatment began: _____ ended: _____

Reason for treatment: _____

b. Name of facility: _____

Address: _____

Telephone #: _____

Date treatment began: _____ ended: _____

Reason for treatment: _____

If additional providers, please attach extra sheets if necessary

31. Have you ever required therapeutic blood testing for medication prescribed for treatment of a mental health disorder?

_____ Yes _____ No

a. When was the last time? _____

b. What were the results? _____

32. Have you experienced suicidal thoughts? _____ Yes _____ No

Have you ever attempted suicide? _____ Yes _____ No

Has any member of your family attempted or committed suicide? _____ Yes _____ No

(Please provide details if you answered “yes” to any of the above questions. Attach additional sheets if necessary.)

33. Please describe any personal consequences you have experienced as a result of your mental health disorder:

MONITORING SECTION

34. Have you ever been a participant in Pennsylvania’s PHMP? (If “yes” provide details, including dates of participation, reason for enrollment, and disposition of your case. Attach additional sheets if necessary):

35. Are you a participant, or have you been a participant of a peer assistance program and/or another state’s monitoring program? (If “yes” provide details, including dates of participation, reason for enrollment, and disposition of your case. Attach additional sheets if necessary):

I, _____,
(Name)

verify that the facts and statements set forth in this Personal Data Sheet are true and correct to the best of my knowledge, information and belief. I understand that statements in this Personal Data Sheet are made subject to the criminal penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Licensee/Applicant Signature Date Social Security Number