COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

Professional Health Monitoring Programs
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# Personal Data Sheet (PDS)

*To be eligible for VRP enrollment individuals must acknowledge their diagnosed substance use and/or mental health disorder(s).*

*The information provided below will be disclosed by the VRP to the Department of State's Legal Office for the attorney responsible for drafting the Board's VRP Consent Agreement to consider for inclusion in the VRP Consent Agreement's Stipulated Facts Section. Once the attorney drafts the VRP Consent Agreement it will be sent to you for your review and signature before being presented to the Board.*

*The VRP Consent Agreement is not considered a public document nor is it considered public discipline. Failure to fully comply with the terms of the Agreement may result in the Agreement becoming public along with public discipline being imposed.*

## Personal Information:

1. Name: _____

2. I am currently receiving mail at: _____
   Street or P.O Box

   _____ _____ _____
   City State Zip Code

## Substance Use and/or Mental Health Diagnosis/Diagnoses:

3. I acknowledge that the following facts are true:

   A. I suffer from the following condition(s) which began on or about:

   _____ _____
   Substance Use/Mental Health/Physical Disorder Date Began

   _____ _____
   Substance Use/Mental Health/Physical Disorder Date Began

   _____ _____
   Substance Use/Mental Health/Physical Disorder Date Began

B. I have suffered the following consequences related to my condition(s):

____ Accident(s) ____ Arrests ____ Financial problems

____ Employment problems ____ Hospitalization(s) ____ Relationship problems

Other (please specify):

C. PHMP-approved evaluator(s):

1. _____ _____
Evaluator's Name Date of Evaluation

2. _____ _____
Evaluator's Name Date of Evaluation

D. Current or most recent treatment provider(s):

1. _____ _____ _____
Provider's Name Date Began Date Ended

_____ _____
Reason (e.g. substance abuse, mental health) Level of Care

2. _____ _____ _____
Provider's Name Date Began Date Ended

_____ _____
Reason (e.g. substance abuse, mental health) Level of Care

**Legal Charge(s)/Conviction(s):**

4. Do you currently have any legal charges pending and/or unresolved in any state or jurisdiction? ____Yes (*Provide Details*) ____No

5. 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 federal or state drug law violations or driving under the influence (DUI)? _____Yes (*Provide Details*) _____No

**Participation in a Monitoring Program:**

6. Have you ever been a participant in Pennsylvania's PHMP? _____Yes _____No
*(If yes, provide participation dates, enrollment reason(s), and disposition of your case)*:

7. Are you enrolled, or have you been enrolled in a peer assistance program and/or another state's monitoring program? _____Yes _____No
*(If yes, provide participation dates, enrollment reason(s), and disposition of your case)*:

I, _____verify that the facts and statements set forth in this document are true and correct to the best of my knowledge, information, and belief.

| _____ | _____ | _____ |
|---|---|---|
| Licensee/Applicant Signature | SSN Last 4 Digits | Date |