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

Professional Health Monitoring Programs
P.O. Box 10569
Harrisburg, PA 17105-0569

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Disciplinary Monitoring Unit Personal Data Sheet

Personal Information:

1. Name: ______________________________ Title: __________

2. Address: ______________________________
Street or P.O. Box

____
City State Zip Code

Do you plan to relocate? _____Yes _____No If yes, when/where: ________________

____

3. Telephone #: ______________________________ ______________________________
Home or Cell Work

4. Email Address: ______________________________

5. Date of Birth: ________________ 6. Last Four Digits of Social Security #: ___________

7. Marital Status: ________________ 8. # of children & ages: ________________

Licensure/Certification and Employment:

9. List all states you hold or held a license to practice.

State: Pennsylvania License # _____________ Status __________________

State: _____________ License # _____________ Status __________________

State: _____________ License # _____________ Status __________________

State: _____________ License # _____________ Status __________________

State: _____________ License # _____________ Status __________________

10. List any other professional certifications you hold or held (e.g. CRNA, CAC)?

State: ______________ Type: _______________ Certification #: ______________

State: ______________ Type: _______________ Certification #: ______________

11. Professional specialty:_______________________________ Degree: _______________

12. Has any action been taken against you by any licensing and/or certification board, or is any such action pending? ___Yes (*Provide Details)* ___No

13. Are you currently employed as a licensed professional? ___Yes (*Provide Details)* ___No

Employer: ____ _______________

Employer's Name Date Hired

Address: ____

Street or P.O Box

____ _____ ___________

City State Zip Code

Supervisor's Name: ___________________________ Phone: _______________________

Is your employer/supervisor aware are in contact with PHMP? ______ Yes ______ No

14. List all places you have been employed in the past three years.

A. Employer: ______________________________ ________________________ ______

Name City State

Employment Dates: ____

Reason(s) for Leaving:____

B. Employer: ______________________________ ________________________ ______

Name City State

Employment Dates: ____

Reason(s) for Leaving:____

C. Employer: ______________________________ ________________________ ______

Name City State

Employment Dates: ____

Reason(s) for Leaving:____

Health Care and Past Medical History:

15. Primary care practitioner: ______________________________
Name

Address: ______________________________
Street or P.O Box

______________________________ ______ ________
City State Zip Code

16. A. Current medical conditions you suffer from:

__________________ __________________

__________________ __________________

__________________ __________________

__________________ __________________

B. Medical conditions you were previously treated for:

__________________ __________________

__________________ __________________

__________________ __________________

__________________ __________________

17. Medications currently prescribed to you:

Medication	Prescriber	Illness/Condition

Substance Use and/or Mental Health Diagnosis/Diagnoses:

18. 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
______________________________	__________
______________________________	__________
______________________________	__________

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 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

Substance Use and/or Mental Health History

19. Have you ever been diagnosed as suffering from a substance use disorder?

_____Yes (C*omplete #19 – #20)* _____No

20. History of the course and symptoms of your substance use disorder:

A. Drug/alcohol use began (include age(s) and duration):

B. Specific drug(s) used/abused:

______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

C. How drugs were obtained:

D. Amount/time/place/pattern of use (describe progression of use/abuse):

E. Date of last use of any alcohol/drug(s) of abuse:______________________________

21. Have you received drug and alcohol treatment in the past? __Yes (*Explain Below*) __No

A. Provider: ______________________________ ______________ ______
Name City State

Date treatment began: _______________ ended: _______________

Reason for treatment:____

B. Provider: ______________________________ ______________ ______
Name City State

Date treatment began: _______________ ended: _______________

Reason for treatment:____

C. Provider: ______________________________ ______________ ______
Name City State

Date treatment began: _______________ ended: _______________

Reason for treatment:____

22. Have you ever been diagnosed as suffering from a mental health disorder?

_____Yes (*Complete #22 – #25*) _____No

23. Mental health disorder(s) diagnosed: ______________________________

24. Have you ever received mental health treatment in the past? __Yes (*Explain Below*) __No

A. Provider: ______________________________ ______________ ______
Name City State

Date treatment began: _______________ ended: _______________

Reason for treatment:____

B. Provider: ______________________________ ______________ ______
Name City State

Date treatment began: _______________ ended: _______________

Reason for treatment:____

C. Provider: ______________________________ ______________ ______
Name City State

Date treatment began: _______________ ended: _______________

Reason for treatment:____

25. Mental health medications currently prescribed:

Medication	Prescriber	Illness/Condition

26. Have you ever been hospitalized for mental health treatment?__Yes (*Explain Below*) __No

A. Facility: ________________________________ ______________ ______
Name City State

Date treatment began: ________________ ended: ________________

Reason for treatment:____

B. Facility: ________________________________ ______________ ______
Name City State

Date treatment began: ________________ ended: ________________

Reason for treatment:____

C. Facility: ________________________________ ______________ ______
Name City State

Date treatment began: ________________ ended: ________________

Reason for treatment:____

<u>Legal Charge(s)/Conviction(s):</u>

27. Do you currently have any legal charges pending and/or unresolved in any state or jurisdiction? _____Yes (*Provide Details*) _____No

28. 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

Monitoring Participation:

29. 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):

30. 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

12/2021