MPO-214 (7/2021)

MUNICIPAL POLICE OFFICERS' EDUCATION AND TRAINING COMMISSION
8002 Bretz Drive
Harrisburg, Pennsylvania 17112-9748
http://www.psp.pa.gov/MPOETC

POST TRAUMATIC STRESS EVALUATION FORM

This form is to be used by PA Licensed Mental Health Professionals to document required Post Traumatic Stress Evaluations.

NOTICE AND INSTRUCTIONS TO EXAMINING MENTAL HEALTH PROFESSIONAL

THIS EXAMINATION SHALL BE ADMINISTERED BY A LICENSED MENTAL HEALTH PROFESSIONAL AS PROVIDED FOR IN THE GOVERNING REGULATIONS, AND SHALL DETERMINE IF THE OFFICER IS EXPERIENCING SYMPTOMS OF PTSD AND IF THE OFFICER IS CLEARED TO RETURN TO FULL DUTY AS A POLICE OFFICER IN PENNSYLVANIA.

LAST NAME	FIRST NAME	MIDDLE INITIAL

STREET ADDRESS	CITY/BORO	STATE	ZIP CODE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	DATE OF EXAM

DUTY STATUS

☐ It is my professional opinion that this individual **IS** experiencing symptoms of Post-Traumatic Stress Disorder but is **CLEARED** to perform the full duties of a police officer in Pennsylvania at this time.

☐ It is my professional opinion that this individual **IS NOT** experiencing symptoms of Post-Traumatic Stress Disorder and is **CLEARED** to perform the full duties of a police officer in Pennsylvania at this time.

☐ It is my professional opinion that this individual **IS** experiencing symptoms of Post-Traumatic Stress Disorder and is **NOT CLEARED** to perform the full duties of a police officer in Pennsylvania at this time.

☐ It is my professional opinion that this individual **IS NOT** experiencing symptoms of Post-Traumatic Stress Disorder but is **NOT CLEARED** to perform the full duties of a police officer in Pennsylvania at this time.

CERTIFICATION STATEMENT BY LICENSED MENTAL HEALTH PROFESSIONAL

I hereby certify that the information and statements contained on this form and in any attached documents are true and correct, and that I am signing this document with the full understanding that any false information or statement will subject me to criminal penalties of Title 18, Crimes code, Section 4904, relating to unsworn falsification to authorities.

SIGNATURE – PENNSYLVANIA LICENSED EXAMINING MENTAL HEALTH PROFESSIONAL _____ DATE _____

MENTAL HEALTH PROFESSIONAL PRINTED NAME	LICENSE NO.	TELEPHONE NO.	

STREET ADDRESS	CITY/BORO	STATE	ZIP CODE

RELEASE OF PSYCHOLOGICAL INFORMATION

I hereby authorize the mental health professional named above to release this form to my employing police department listed below. No other release of this information, explicit or implied, is granted at this time.

NAME OF MUNICIPAL POLICE DEPARTMENT (Print) _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ FAX _____ EMAIL _____

SIGNATURE OF OFFICER _____ DATE _____