COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
PROFESSIONAL HEALTH MONITORING PROGRAMS (PHMP)
PO BOX 10569
HARRISBURG, PA 17105-0569
1-800-554-3428
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www.dos.state.pa.us

PDS

# PERSONAL DATA SHEET

1. NAME: _____ DATE: _____

2. ADDRESS: _____
Street or P.O. Box

_____ _____
City State Zip County

Length of time at this residence? _____

Plan to relocate? _____Yes ____ No

If yes, when and where_____

_____

TELEPHONE #: _____ _____
Home Work

4. Birth Date: _____/_____/_____ 5. _____
Month Day Year Driver's License Number

6. Social Security #_____ 7. Marital Status: (S/M/Sep/Div/Cohab) ___

# of children and ages:_____

8. Nature of Problem: (Please check all appropriate categories)

_____ Alcohol
_____ Other Drug
_____ Psychological/Mental
_____ Physical (**please include and specify all chronic conditions such as diabetes, hypertension, etc.**)

_____

Are you currently being treated for any of the problems listed above: _____Yes ____ No

**DRUG & ALCOHOL TREATMENT:**

Current treatment program/provider(s)(Name, address, telephone #):

_____

_____

_____

Phone: _____

Date treatment began? _____ ended? _____

Name of Aftercare/Continuing Care Counselor:

Name: _____

Address: _____

Phone: _____

Date treatment began? _____ ended? _____

9. Have you ever received drug and alcohol treatment in the past? ____ Yes ___ No

If yes, when? _____

*Name of treatment program/provider: _____

Address: _____

_____

Date treatment began? _____ ended? _____

*Name of treatment program/provider: _____

Address: _____

_____

Date treatment began? _____ ended? _____

**List <u>ALL</u> prior drug & alcohol and/or mental health treatment (attach extra sheets as needed).**

10. Name, address and phone number of your **personal/family physician**:

Name:_____ Phone #:_____

Address:

_____

11. List **ALL** medications you are currently taking and the name, address and telephone number of the physician who prescribed the medication.

_____ _____

_____ _____

_____ _____

12. **Employment**: Are you currently employed? _____ Yes _____ No

If yes: Name of Employer: _____

Address: _____

_____

Telephone # _____

Name of Supervisor:_____

Date of hire:_____

Is your employer aware you contacted the Professional Health Monitoring Program? _____ Yes _____ No

13. List all places you have been employed in the past three years. Please include name, address, and supervisor. (attach additional sheets if more space is needed):

a) Name: _____

Address: _____

Supervisor: _____ Phone #:_____

Dates of Employment:_____

b) Name: _____

Address: _____

Supervisor: _____ Phone #:_____

Dates of Employment:_____

14. List all states where you hold/held a license to practice (List state and license status, active or inactive).

State: **Pennsylvania** License Number _____ Status _____

State: _____ License Number _____ Status _____

State: _____ License Number _____ Status _____

15. Do you hold any other professional license? _____ Yes _____ No
(e.g., Registered Nurse also licensed as a Practical Nurse; a CRNA?)

If yes, State: _____ Type _____

License Number: _____

15(a) Has any action been taken against you by any licensing board, or is any such action pending? (provide details. Attach additional sheets if more space is needed):

15(b) Are you currently, or have you even been, a participant in the PHMP or **another** state's monitoring program? (provide details. Attach additional sheets if more space is needed):

16. Professional specialty (if any: e.g., anesthesiology):

**17. Has any** civil/criminal action been taken against you, or is any action pending? Provide details.

18. I freely and voluntarily acknowledge that the following facts are true:
I suffer from: _____
(impairment: chemical dependency/abuse; specifically

_____
diagnosed mental health/psychological/emotional illness;

_____
physical problem/illness; other).

which I began to develop approximately _____
(date/time/life situation)

_____

## CHEMICAL DEPENDENCY/ABUSE:

The following represents a brief history of the course and symptoms of my chemical dependency/abuse: (please include answers to all following questions relevant to your situation: drug/alcohol use began when? duration? drug(s) of choice? How obtained? "reason" for use? amount/time/place/pattern of use? describe progression of the illness; last use? for example: "used between 5 and 10 percocet daily, diverted from work, both on and off the job; also drank 1-2 sixpacks of beer a night, for three years. progressed to 10 percocet and one pint blended whiskey daily for six months. Stopped percocet 2-3 months ago; still drinking about a pint a day, more on weekends."

The following represents a brief description of the consequences resulting from my chemical dependency/abuse: (for example: accidents; overdoses; hospitalizations; treatment; arrests; employment termination's; quitting to avoid getting fired, caught, or reported; work performance problems; family/relationship problems; self injury; etc).

**MENTAL/PSYCHOLOGICAL/EMOTIONAL ILLNESS:**

Have you ever considered suicide? _____ Yes _____ No

Have you ever attempted suicide? _____ Yes _____ No

Has any member of your family ever committed suicide? _____ Yes _____ No
(Please provide details if you answer "Yes" to any of the above questions. Attached sheet if needed.)

Are you currently being treated for depression? _____Yes _____ No

Have you ever been treated for depression? _____Yes _____ No

If yes, who is/was treating you?

Name: _____

Address: _____

_____

Telephone #: _____

Dates of treatment for depression? _____

Where were you treated? _____

_____

_____

_____

_____

Medications prescribed for this illness (please provide name of any medication, dosage, and number of times a day taken):

Have you ever been hospitalized for treatment of depression? _____Yes _____No

If yes, please describe the circumstances and provide the name(s) of the hospital(s) and date(s) of hospitalization(s). _____

_____

_____

_____

_____

_____

Are you currently being treated for manic-depressive illness? _____Yes _____No

Have you ever been treated for manic-depressive illness? _____Yes _____No

If yes, who is/was treating you?

(Name _____ address _____ telephone #) _____

_____

_____

_____

Dates of treatment for this illness? _____

_____

_____

_____

Where were you treated? _____

Medications prescribed for this illness (please provide name of any medication, dosage and # times a day taken)_____

_____

_____

_____

Have you had blood testing done to determine blood levels of these medications? _____Yes _____No

If yes, when was the last time? _____

Do you know the results? _____Yes _____No

If yes, what were they?_____

Have you ever been hospitalized for manic-depressive illness? _____Yes _____No

If yes, please describe the circumstances and provide the name of the hospital(s) and the date(s) of hospitalization(s).

_____

_____

_____

_____

_____

Have you ever been diagnosed as having any other emotional, psychological, or mental difficulties? _____Yes _____No

If yes, when? _____

By whom? _____
(Name, address, telephone #.)

_____

What was/were the diagnosis(es)?

_____

_____

What was the recommended treatment?

_____

_____

If treatment was recommended, did you follow through with it? _____Yes _____No

Explain:_____

_____

_____

Please describe any personal consequences you have experienced as a result of depression, manic depressive, or other emotional, psychological or mental illnesses: for example, legal, social, or practice problems

_____

_____

_____

_____

_____

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