



Pennsylvania
Department of State

Professional Health Monitoring Programs (PHMP)
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: _____



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

State: _____ Type: _____ Certification #: _____
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: _____



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Health Care and Past Medical History:

15. Primary care practitioner: _____

Address: _____

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



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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
_____	_____
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 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	



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Substance Use and/or Mental Health History:

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

____ Yes (Complete #20 – #21) ____ 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: _____



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21. Have you received drug and alcohol treatment in the past? Yes (explain below) No

A. Provider Name: _____ City: _____ State: _____

Treatment Dates: _____ Treatment Reason(s): _____

B. Provider Name: _____ City: _____ State: _____

Treatment Dates: _____ Treatment Reason(s): _____

C. Provider Name: _____ City: _____ State: _____

Treatment Dates: _____ Treatment Reason(s): _____

D. Provider Name: _____ City: _____ State: _____

Treatment Dates: _____ Treatment Reason(s): _____

22. Have you ever been diagnosed as suffering from a mental health disorder?
 Yes (Complete #23 – #26) 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: _____

Treatment Dates: _____ Treatment Reason(s): _____

B. Provider Name: _____ City: _____ State: _____

Treatment Dates: _____ Treatment Reason(s): _____

C. Provider Name: _____ City: _____ State: _____

Treatment Dates: _____ Treatment Reason(s): _____



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25. Medications currently prescribed to you:

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

26. Have you ever been hospitalized for mental health treatment? _____ Yes (explain below) _____ No

A. Facility Name: _____ City: _____ State: _____

Treatment Dates: _____ Treatment Reason(s): _____

B. Facility Name: _____ City: _____ State: _____

Treatment Dates: _____ Treatment Reason(s): _____

C. Facility Name: _____ City: _____ State: _____

Treatment Dates: _____ Treatment Reason(s): _____

Legal Charge(s)/Conviction(s):

27. Do you currently have any legal charges pending and/or unresolved in any state or jurisdiction?

_____ Yes (provide details) _____ No



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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

Participation in a Monitoring Program:

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

Date

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