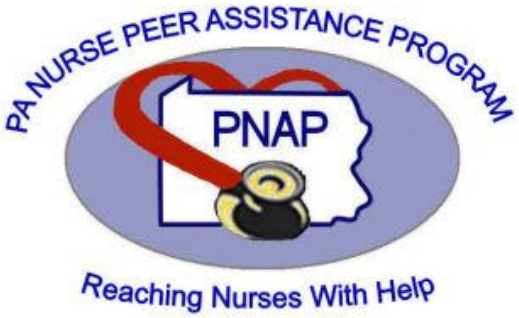

PERSONAL DATA SHEET (PDS)

1. Name: _____

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

_____
City State Zip Code

County:_____ Length of time at this residence:_____

Do you plan to relocate? _____Yes _____No

If yes, when and where: _____

_____

3. Telephone #: _____ _____
Home or Cell Work

4. Date of Birth: _____ 5. Driver's License #:_____

6. Social Security #:_____ 7. Marital Status:_____

8. Number of children and ages: _____

LICENSURE/CERTIFICATION SECTION:

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

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

State: _____ License Number _____ Status _____

State: _____ License Number _____ Status _____

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

State: _____ Type: _____ Certification #: _____

State: _____ Type: _____ Certification #: _____

11. Professional specialty (If any: e.g. anesthesiology, critical care, etc…):

12. Has any action been taken against you by any licensing and/or certification board, or is any such action pending? (If yes, provide details. Attach additional sheets if necessary):

EMPLOYMENT SECTION:

13. Are you currently employed? _____ Yes _____ No

Name of employer: _____

Address: _____

_____

Name of supervisor: _____

Phone: _____ Date of hire: _____

Is your employer aware you contacted the PHMP? _____ Yes _____ No

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

a) Name of employer: _____

Address: _____

Name of supervisor: _____

Phone: _____ Dates of employment:_____

b) Name of employer: _____

Address: _____

Name of supervisor: _____

Phone: _____ Dates of employment:_____

Please attach extra sheets if you had additional employers in the past three years.

LEGAL SECTION:

15. Do you currently have any criminal charges filed against you or is any action pending in any court or jurisdiction? (If yes, provide details. Attach additional sheets if necessary):

16. 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 drug law violations or driving under the influence (DUI)? (If yes, provide details. Attach additional sheets if necessary):

HEALTH CARE/MEDICAL SECTION:

17. Nature of problem: (Please check all appropriate categories):

_____ Alcohol _____ Other Drug _____ Mental Health _____Physical

Specify all chronic conditions (e.g. diabetes, hypertension, etc…): _____

_____

_____

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

18. Name of your primary health care practitioner:_____

Address: _____

Phone #: _____

19. List **ALL** medications you are currently taking, the name of the prescribing practitioner, and the condition or illness. (Attach additional sheets if necessary):

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

PHMP-APPROVED EVALUATION SECTION:

20. Name of your PHMP-approved evaluator: _____

21. Date of your PHMP-approved evaluation: _____

SUBSTANCE USE SECTION:

22. Are you suffering from or have you previously been diagnosed as suffering from a substance use disorder? _____Yes _____No

If yes, complete #23 – #26.

23. I acknowledge that the following facts are true:

I suffer from: _____
(Specify type of substance use disorder)

which I began to develop approximately: _____
(Date)

24. The following represents a brief history of the course and symptoms of my substance use disorder:

a. My drug/alcohol use began (include age(s) and duration):

b. Specific drug(s) used/abused (e.g. percocet, vicodin, cocaine, alcohol, etc…):

c. How drugs were obtained:

d. Reason(s) for use:

e. Amount/time/place/pattern of use (describe progression of the illness; for example: "used between 5 and 10 percocet daily, diverted from work, both on and off the job; also drank 1-2 six packs of beer a night, for three years; progressed to 10 percocet and one pint blended whiskey daily for six months.")

f. Date of last use of any drug(s) of abuse (including alcohol):

g. List any consequences you suffered as a result of your substance use disorder: (e.g. accidents; overdoses; hospitalizations; treatment; arrests; decline in work performance; employment problems; family/relationship problems; etc).

DRUG & ALCOHOL TREATMENT:

25. Name of current treatment program/provider: _____

Address: _____

_____

Telephone #: _____

Date treatment began: _____ ended: _____

Name of aftercare/continuing care counselor: _____

Address: _____

_____

Telephone #: _____

Date treatment began: _____ ended: _____

26. Have you ever received drug and alcohol treatment in the past? _____Yes _____No

a. Name of treatment program/provider: _____

Address: _____

_____

Telephone #: _____

Date treatment began: _____ ended: _____

Reason for treatment:_____

b. Name of treatment program/provider: _____

Address: _____

_____

Telephone #: _____

Date treatment began: _____ ended: _____

Reason for treatment:_____

If additional providers, please attach extra sheets if necessary

MENTAL HEALTH SECTION:

27. Have you been diagnosed as suffering from a mental health disorder?
_____Yes _____No

If yes: complete #28 – #33.

28. I acknowledge that the following facts are true:

I suffer from: _____
(Specify type of mental health disorder)

which I began to develop approximately: _____
(Date)

29. Are you currently or have you ever been treated for a mental health disorder (e.g. Depression, Bipolar Disorder, Anxiety, PTSD, Personality Disorder, etc…)?

_____ Yes _____ No

Specify mental health disorders: _____

_____

_____

a. Name of treatment provider: _____

Address: _____

_____

Telephone #: _____

Date treatment began: _____ ended: _____

Reason for treatment:_____

b. Name of treatment provider:_____

Address: _____

_____

Telephone #: _____

Date treatment began: _____ ended: _____

If additional providers, please attach extra sheets if necessary

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

_____

_____

_____

30. Have you ever required hospitalization for treatment of a mental health disorder?

_____Yes _____No

a. Name of facility: _____

Address: _____

_____

Telephone #: _____

Date treatment began: _____ ended: _____

Reason for treatment:_____

b. Name of facility: _____

Address: _____

_____

Telephone #: _____

Date treatment began: _____ ended: _____

Reason for treatment:_____

If additional providers, please attach extra sheets if necessary

31. Have you ever required therapeutic blood testing for medication prescribed for treatment of a mental health disorder?

_____Yes _____No

a. When was the last time? _____

b. What were the results? _____

32. Have you experienced suicidal thoughts? _____ Yes _____ No

Have you ever attempted suicide? _____Yes _____ No

Has any member of your family attempted or committed suicide? _____Yes _____ No

(Please provide details if you answered "yes" to any of the above questions. Attach additional sheets if necessary.)

33. Please describe any personal consequences you have experienced as a result of your mental health disorder:

MONITORING SECTION

34. Have you ever been a participant in Pennsylvania's PHMP? (If "yes" provide details, including dates of participation, reason for enrollment, and disposition of your case. Attach additional sheets if necessary):

35. Are you a participant, or have you been a participant of a peer assistance program and/or another state's monitoring program? (If "yes" provide details, including dates of participation, reason for enrollment, and disposition of your case. Attach additional sheets if necessary):

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