XVIII. PHYSICAL AND MENTAL HEALTH STATUS **If you answered "Yes" to any questions BELOW, please describe all physical and/or mental disabilities you have which impair or could impair your ability to carry out your professional obligations in a manner that meets the standards of care in the community and the Bylaws, Rules and Policies of this Hospital and Medical Staff, and the accommodations that could be made to enable you to practice at SFGH**:

A. Do you have any physical or mental disability which impairs or could impair your ability to carry out your professional obligations in a manner that meets the standards of care in the community and the Bylaws, Rules and Policies of this Hospital and Medical Staff? (When answering this question, please consider all types of physical or mental disability, including past or present substance abuse.)	**Yes [ ]**	**NO [ ]**
B. Do you have any communicable health conditions that could pose any significant health and safety risk to your patients?	**Yes [ ]**	**NO [ ]**
C. Do you have a history of chemical dependency or substance abuse that might adversely affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?	**Yes [ ]**	**NO [ ]**
D. If you answered A, B or C yes, could accommodations be made to allow you to practice at the Hospital?	**Yes [ ]**	**NO [ ]**

XIX. CONFIDENTIALITY AGREEMENT

CHECK HERE [ ] TO CERTIFY THE FOLLOWING:

As a member, participant or invitee of a San Francisco Health Network Medical Staff Committee involved in the evaluation and improvement of the quality of care rendered in the hospital, I recognize that confidentiality is vital to the free and candid discussions necessary to effective medical staff peer review activities. Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records, and other information generated in connection with these activities, and to make no voluntary disclosure of such information except to persons authorized to receive it in the conduct of Medical Staff affairs. Furthermore, my participation in peer review and quality assurance activities is in reliance on my belief that the confidentiality of these activities will be similarly preserved by each member of the Medical Staff, hospital employee, or other individual involved. I understand that Hospital and Medical Staff are entitled to undertake such actions as is deemed appropriate to ensure that this confidentiality is maintained, including this agreement.

Signature: _____

Print Name: _____

XX. ~~PEER~~ REFERENCES: List **3** peer references from your specialty AND licensure area, EXCLUDING your SFGH Service Chief, relatives, and financial partners. Include at least one member from the Medical Staff of each facility at which you currently have privileges/patient care responsibilities. NOTE: References must include at least one supervisor who supervised your clinical work (**at least 6 months duration and within the past year**), either via direct clinical observation or through close clinical working relationship at the site you have worked most often.

1.) Supervisor's Name, Degree & Title	Relationship:			PHONE: FAX:
Street Address:	City:	State:	ZIP:	EMAIL:
2.) ~~Peer's~~ Name, Degree & Title:	Relationship:			PHONE: FAX:
Street Address:	City:	State:	ZIP:	EMAIL:
3.) ~~Peer's~~ Name, Degree & Title:	Relationship:			PHONE: FAX:
Street Address:	City:	State:	ZIP:	EMAIL: