SACRED HEART HOSPITAL
EAU CLAIRE, WISCONSIN

MEDICAL STAFF BYLAWS

Revised: July 11, 2019

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ADOPTION

1. These Medical Staff Bylaws and Policies are adopted and made effective upon approval of the Board of Directors of Sacred Heart Hospital of the Hospital Sisters of the Third Order of St. Francis, superseding and replacing any and all previous Medical Staff Bylaws, and henceforth all activities and actions of the Medical Staff and of each individual exercising clinical privileges at the Hospital shall be taken under and pursuant to the requirements of these Medical Staff Bylaws, including all of their Parts.

2. The present rules and regulations of the Medical Staff are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws.

Revisions adopted by the Sacred Heart Hospital Medical Staff:

Date: June 18, 2018

Approved by the Board of Directors of Sacred Heart Hospital of the Hospital Sisters of the Third Order of St. Francis:

Date: July 12, 2018

MEDICAL STAFF BYLAWS AND POLICIES

The Medical Staff Bylaws shall be applicable to all Medical Staff appointees and, as appropriate, to other individuals who have been granted clinical privileges or a scope of practice, and shall be an integral part of the Medical Staff Bylaws, subject to the amendment provisions contained in each Part.

TIME LIMITS

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

DELEGATION OF FUNCTIONS

When a function is to be carried out by a member of Hospital administration, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chairperson, may delegate performance of the function to one or more qualified designees.

PREAMBLE

WHEREAS, the Board of Directors of Sacred Heart Hospital of the Hospital Sisters of the Third Order of St. Francis (the "Board") recognizes that each physician, dentist and podiatrist appointed to the Medical Staff has responsibility for the exercise of professional judgment in the care and treatment of patients; and

WHEREAS, the Board, in accordance with legal and accreditation requirements, has delegated to the Medical Staff, through its clinical services and committees, the duties and responsibilities set forth in these Medical Staff Bylaws for supervising and monitoring the quality of care provided by physicians, dentists, podiatrists and other health care professionals in the Hospital, and for making recommendations concerning application for appointment, reappointment, clinical privileges or scope of practice; and

WHEREAS, the Medical Staff recognizes and accepts its role and responsibilities in the efforts of the Hospital to foster prevention, amelioration and cure of illness, disease and injury, and to provide or assist in providing medical education and continuing medical education for Medical Staff appointees, other health care professionals, and residents, interns, medical students and nurses;

THEREFORE, to discharge those duties and responsibilities, and to provide for an orderly process concerning matters of election, meetings, duties and procedures, the officers, clinical

services and committees of the Medical Staff as described in these Medical Staff Bylaws assume responsibility for fulfilling those duties and functions delegated to them by the Board.

ARTICLE I

DEFINITIONS

The following definitions shall apply to terms used in these Bylaws:

(1) "Allied health professional" means an individual, other than a licensed physician, dentist or podiatrist, whose patient care activities require that his or her authority to perform specific patient care services or to exercise specific clinical privileges or a scope of practice be processed through Medical Staff channels or with involvement of Medical Staff representatives.

(2) "Appointee" means any physician, dentist and podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.

(3) "Authorized representatives" means any persons who have responsibility for obtaining or evaluating credentials, acting upon applications, or conducting professional review activity, including Board members, Medical Staff appointees or committee members, Hospital employees, consultants and legal counsel.

(4) "Automatic relinquishment" of clinical privileges or scope of practice means a lapse in clinical privileges or scope of practice deemed to automatically occur as a result of stated conditions.

(5) "Board" means the Board of Directors of Sacred Heart Hospital of the Hospital Sisters of the Third Order of St. Francis.

(6) "Board Certification" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties ("ABMS"), the American Osteopathic Association ("AOA"), the Royal College of Physicians and Surgeons of Canada, or the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, as applicable, upon a physician, dentist, or podiatrist who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice.

(7) "Chief Executive Officer" or "CEO" means the individual appointed by the Governing Board to act on its behalf in the overall management of the Hospital.

(8) "Chief Medical Information Officer" or "CMIO" means the individual appointed by the Hospital to be generally responsible for the health informatics platform and management of medical information in collaboration with the Medical Staff.

(9) “Chief Physician Executive” or “CPE” means the individual appointed by the Hospital to act as the Chief Physician Executive of the Hospital, in cooperation with the President of the Medical Staff.

(10) “Clinical privileges” or “privileges” means the authorization granted by the Board to an applicant, Medical Staff appointee or other independent or advanced dependent practitioner to render specific patient care services in the Hospital within defined limits.

(11) “Collaborating practitioner” means a member of the Medical Staff with clinical privileges, who has agreed in writing to collaborate with an allied health professional requiring collaboration.

(12) “Collaboration” means a process involving two or more health care professionals working together and, when necessary, in each other’s presence, and in which each health care professional contributes his or her expertise to provide more comprehensive care than one health care professional can offer alone.

(13) “Corrective Action” means the termination of medical staff membership or a restriction, reduction, modification, or termination of medical staff privileges for reasons of clinical incompetence or unprofessional conduct.

(14) “CVO” means the Credentials Verification Office.

(15) “Days” means calendar days.

(16) “Dentist” shall be interpreted to include a doctor of dental surgery (“D.D.S.”) and doctor of dental medicine (“D.M.D.”).

(17) “Emergency Call” means the responsibility to accept unassigned patients in accordance with the on-call policy.

(18) “EMR” means the electronic medical record.

(19) “Ex officio” means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided in these Bylaws, means without voting rights.

(20) “Federal health program” means Medicare, Medicaid or any other federal or state program providing health care benefits which is funded directly or indirectly by the United States government.

(21) “Good standing” means that Medical Staff appointee who is not under suspension or any restriction regarding staff appointment or admitting or clinical privileges at this Hospital and/or at any other health care facility or organization.

(22) “Hospital” means Sacred Heart Hospital of the Hospital Sisters of the Third Order of St. Francis.

(23) “Hospital Administration” means the Chief Executive Officer or his or her designee, including the administrator on call.

(24) “Locum Tenens” means a practitioner who has been granted temporary privileges for the sole purpose of holding the place of a Medical Staff member during a period of temporary unavailability.

(25) “Medical Executive Committee” means the Executive Committee of the Medical Staff unless specifically written “Executive Committee of the Board.”

(26) “Medical Staff” means all physicians, dentists and podiatrists who are granted privileges to treat patients at the Hospital.

(27) “Medical Staff Leader” means any Medical Staff officer, department chairman, or committee chairman.

(28) “Medical Staff year” means the period from July 1st to June 30th.

(29) “Member” means any physician, dentist, podiatrist, and psychologist who has been granted Medical Staff appointment by the Board to practice at the Hospital.

(30) “Notice” means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail, hand delivery, or posting.

(31) “Oral Surgeon” means a licensed dentist who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the American Association of Oral and Maxillofacial Surgery and/or the Commission on Dental Education of the American Dental Association.

(32) “Organized Health Care Arrangement” " means the term used by the HIPAA Privacy Rule to describe a clinically-integrated care setting in which patients typically receive health care from more than one provider (such as a hospital and its Medical Staff) and which benefits from regulatory provisions designed to facilitate compliance with the HIPAA Privacy Rule.

(33) “Patient Contacts” may include admissions, consultations, procedures, responses to emergency call, evaluations, treatments or services performed in any facility operated by the Hospital or an affiliate, including outpatient facilities, or, alternatively, may be defined by the departments and approved by the Medical Executive Committee.

(34) “Physicians” shall be interpreted to include both doctors of medicine (“M.D.s”) and doctors of osteopathy (“D.O.s”).

(35) "Podiatrist" shall be interpreted to mean a doctor of podiatric medicine ("D.P.M.").

(36) "Prerogative" means a participatory privilege granted by virtue of staff category assignment, to a Medical Staff appointee and which may be exercised subject to the conditions imposed by these Bylaws and other applicable bylaws documents and Medical Staff policies.

(37) "Professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional peer review activity, which is based on the competence or professional conduct of an appointee, and which affects or may affect adversely the clinical privileges or appointment of the staff appointee.

(38) "Professional review activity" means a peer review activity of the Hospital with respect to an individual Medical Staff applicant or appointee (a) to determine whether the Medical Staff applicant or appointee may have appointment and clinical privileges; (b) to determine the scope or conditions of appointment and clinical privileges; and (c) to change or modify appointment and/or clinical privileges.

(39) "Professional review body" means the Board of the Hospital or any Board committee which conducts professional peer review activity, and includes any committee of the Medical Staff when assisting the Board in a professional peer review activity.

(40) "Scope of practice" means the authorization granted by the Board or the CEO, as applicable, to allied health professionals to perform certain clinical activities, tasks and functions consistent with applicable state statutes and regulations, and Medical Staff rules and regulations, and policies.

(41) "Self-government" means the duty of the Medical Staff officers, committees and clinical services, including their sections, to initiate and carry out the functions delegated by the Board and to fulfill the obligations provided for in these Bylaws.

(42) "Special notice" means written notification sent by certified mail, return receipt requested. When calculating the time for giving special notice, Sundays and holidays shall not be counted.

(43) "Sponsoring practitioner" means a member of the Medical Staff with clinical privileges, who has agreed to provide oversight for an allied health professional.

(44) "Supervising practitioner" means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise an allied health professional requiring supervision and to accept responsibility for the actions of the allied health professional while that individual is practicing in the Hospital.

(45) “Third parties” includes, but is not limited to, other hospitals, health care facilities/entities, government agencies, former employers, insurers, and managed care plans.

(46) “Unassigned patient” means any individual who comes to the Hospital for care and treatment who has not been referred by or has not been the patient of a group/clinic affiliation with a physician on staff at the Hospital, or who does not express a desire for the medical services of a particular appointee, or whose attending physician or designated alternate is unavailable.

(47) “Voluntary” or “automatic relinquishment” of Medical Staff appointment and/or clinical privileges means a lapse in appointment or clinical privileges deemed to automatically occur as a result of stated conditions.

Words used in these Bylaws shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

ARTICLE II

GENERAL PROVISIONS

Part A. Medical Staff Responsibilities Summarized:

The responsibilities of the Medical Staff, to be fulfilled through the actions of its officers, clinical departments and committees, shall include:

(1) accountability for the quality and appropriateness of patient care rendered by all Medical Staff appointees and allied health professionals who are authorized to practice in the Hospital pursuant to the Hospital’s credentialing processes for initial appointment, reappointment, and for clinical privileges, continuing medical education programs for staff appointees and Hospital personnel and students, utilization review program, and quality assessment/performance improvement activities, including, but not limited to, valid and reliable patient care audit procedures; and

(2) assisting the Board and Hospital administration to identify community health needs and in setting appropriate institutional goals and implementation plans to meet those needs.

Part B. Confidentiality and Peer Review Protections:

Section 1. Confidentiality:

Actions taken and recommendations made pursuant to these Bylaws shall be strictly confidential. Individuals participating in, or subject to, credentialing and peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:

(a) When the disclosures are to another authorized member of the Medical Staff, the CEO, legal counsel or authorized Hospital employee and are for the purpose of conducting legitimate credentialing and peer review activities; or

(b) When disclosures are authorized by a Medical Staff or Hospital policy.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

Section 2. Peer Review Protections.

(a) All credentialing and peer review activities pursuant to these Bylaws and related Medical Staff documents shall be performed by "Peer Review Committees" in accordance with Wis. Stat. Ann. §146.37, §146.38 and other applicable Wisconsin law. Peer review can occur:

(1) at all standing and ad hoc Medical Staff and Hospital committees;

(2) at hearing panels;

(3) at the Board and its committee meetings;

(4) by any individual acting for or on behalf of any such entity, including but not limited to department Chairmen, committee chairs and members, officers of the Medical Staff, and experts or consultants retained to assist in peer review activities; and

(5) at all department meetings.

All oral and written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of Wis. Stat. Ann. § 146.38.

(b) All peer review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. '11101 *et seq.*

Part C. Corporate Compliance:

All Medical Staff appointees shall cooperate fully with the Corporate Compliance Policy of Sacred Heart Hospital and adhere to all laws, regulations and standards of conduct applicable to their

activities at the Hospital, the practice of their profession, and their participation in any federal health program, as a condition of their continued appointment to the Medical Staff. In the event that any Medical Staff appointee knows or suspects that he or she or any director, officer, employee or other Medical Staff appointee has violated applicable laws or regulations, that appointee shall immediately report the matter to the CEO or the Corporate Compliance Officer.

Part D. Conflict of Interest:

1. When performing a function outlined in these Bylaws or the Medical Staff Rules and Regulations, if any Medical Staff member has or reasonably could be perceived as having a conflict of interest or a bias in any credentialing or peer review matter involving another individual, the individual with a conflict shall not participate in the final discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may provide relevant information and may answer any questions concerning the matter before leaving.

2. Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of President of the Medical Staff (or to the President-Elect if the President of the Medical Staff is the person with the potential conflict), or the applicable department or committee chair. The President of the Medical Staff or the applicable department chairman or committee chair shall make a final determination as to whether the provisions in this Article should be triggered.

3. The fact that a department chairman or staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel disqualification of another staff member based on an allegation of conflict of interest.

4. The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

Part E. Indemnification when Performing Credentialing and Peer Review Functions:

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, department chairs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by law, in accordance with the Hospital's bylaws.

ARTICLE III

CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be made by the Board and shall be to one of the following categories of the staff. All appointees shall be assigned to a specific clinical department, but shall be eligible for clinical privileges in other clinical departments as applied for and recommended pursuant to these Bylaws and approved by the Board. The prerogatives described herein for specific staff categories are general in nature and may be subject to limitation by special conditions imposed on the appointee's staff appointment pursuant to other sections of these Bylaws, the Medical Staff Rules and Regulations, or by policies of the Hospital.

Part A. Active Staff:

Section 1. Qualifications:

The Active Staff shall consist of those physicians, dentists and podiatrists who:

(a) meet the qualifications for appointment as set forth in Article VI;

(b) are professionally based in the community served by the Hospital, close enough to provide timely and continuous care to their patients in the Hospital and to fulfill their staff responsibilities; and

(c) attend, admit or are involved in the treatment or care of at least ten (10) patients per year at the Hospital.

Section 2. Responsibilities and Prerogatives:

By accepting appointment to the Active Staff, each individual shall:

(a) agree to assume all the functions and duties of the Active Staff including specifically, and where appropriate, care for unassigned patients, coverage for emergency service care, consultation and teaching assignments, and participation in quality assessment and monitoring activities;

(b) exercise only those clinical privileges granted by the Board;

(c) attend Medical Staff and clinical department and committee meetings, as applicable;

(d) be entitled to vote on all matters presented at general and special meetings of the Medical Staff and the clinical department and committees of which the appointee is a member;

(e) serve as needed as clinical department chairperson or chairperson of Medical Staff committees;

(f) serve as a Medical Staff officer provided they have been an Active Staff member for at least five (5) years;

(g) participate in the peer review and performance improvement programs as requested and/or required by the Hospital; and

(h) pay staff dues and assessments.

Part B. Courtesy Staff:

Section 1. Qualifications:

The Courtesy Staff shall consist of those physicians, dentists and podiatrists who:

(a) meet the qualifications for appointment as set forth in Article VI;

(b) are professionally based in the community served by the Hospital, close enough to provide timely and continuous care to their patients in the Hospital; and

(c) attend, admit or are involved in the treatment or care of fewer than ten (10) patients per year, including consultations, at the Hospital: and

(d) Shall automatically be placed on Active Staff if involved in the treatment or care of more than ten (10) patients per year and will remain on Active Staff for one (1) year.

Section 2. Responsibilities and Prerogatives:

By accepting appointment to the Courtesy Staff, each individual shall:

(a) agree to follow the individual's patients in the Hospital and to provide medical consultation upon the request of an attending practitioner on the Medical Staff;

(b) exercise only those clinical privileges granted by the Board;

(c) have the right to attend meetings of the Medical Staff and meetings of the clinical department of which the appointee is a member;

(d) have the right to attend Medical Staff and Hospital educational programs;

(e) not be eligible to vote except when serving on a committee, or to hold Medical Staff office or to serve as clinical department chairperson;

(f) participate in the peer review and performance improvement programs as requested and/or required by the Hospital; and

(g) shall pay dues and assessments.

Part C. Coverage Staff:

Section 1. Qualifications:

The Coverage Staff shall consist of individuals of demonstrated competence qualified for Medical Staff appointment, who:

(a) provide or are members of a coverage group which provides periodic coverage for a practitioner who is an Active Staff appointee in good standing;

(b) have an appointment at another hospital or other clinical practice entity; and

(c) provide, at reappointment, evidence of clinical performance (performance profile) at their primary hospital or clinical practice entity in such form as may be requested by the Hospital.

Section 2. Prerogatives and Responsibilities:

Coverage Staff appointees:

(a) shall assume all functions and responsibilities required to provide coverage for other members of their coverage group, including, where appropriate, care for service patients, emergency service care and consultations;

(b) may attend and participate in Medical Staff and clinical department meetings, without vote;

(c) may not hold office or serve as clinical department chairperson;

(d) shall participate in the peer review and performance improvement programs as requested and/or required by the Hospital; and

(e) shall pay dues and assessments.

Part D. Consulting Staff:

Section 1. Qualifications:

The Consulting Staff shall consist of practitioners of recognized professional ability and expertise who are not appointed to another category of the Medical Staff, who provide a service(s) that is not available from an Active Staff appointee, and who are appointed to the medical staff at another hospital where they are currently practicing. Consulting Staff appointees must meet the qualifications for appointment as set forth in these Bylaws, and must provide such quality data and other information as may be requested from time to time to assist in an appropriate assessment of their current clinical competence and overall qualifications.

Section 2. Prerogatives and Responsibilities:

Consulting Staff appointees:

(a) may treat (but not admit) patients in conjunction with another physician on the Active Staff;

(b) shall participate in the peer review and performance improvement programs as requested and/or required by the Hospital;

(c) must provide consultation when requested by an attending Medical Staff appointee or the clinical department chairperson;

(d) must exercise only those clinical privileges granted by the Board;

(e) may attend meetings of the Medical Staff and applicable clinical department meetings, without vote, and applicable committee meetings, with vote;

(f) are not eligible to admit patients to the hospital, but may treat patients if granted clinical privileges to do so;

(g) may not hold Medical Staff office or serve as clinical department chairperson;

(h) are encouraged to communicate with hospitalists and/or other Active, Courtesy and Consulting Staff members about the care of any patients referred to them;

(i) may petition the Medical Executive Committee to address a matter of concern which has not been adequately resolved via discussion with the hospitalist involved or chairperson of the Medicine Department. Such petition must be submitted in writing addressed to the President of the Medical Staff;

(j) shall pay dues and assessments.

Part E. Affiliate Staff:

Section 1. Qualifications:

The Affiliate Staff will consist of members of the Medical Staff who:

(a) desire to be associated with, but who do not intend to establish a practice at, this Hospital;

(b) are interested in pursuing professional and educational opportunities, including continuing medical education, available at the Hospital; and

(c) satisfy the qualifications for appointment set forth in Article VI: Part A. Section 1 b)(1) and (5) of these Bylaws.

Section 2. Prerogatives and Responsibilities:

(a) Affiliate Staff Members:

(1) may attend meetings of the Medical Staff and applicable department (without vote);

(2) may not hold office or serve as a department chair;

(3) may be invited to serve on committees (with vote), including serving as committee chair;

(4) may attend educational activities sponsored by the Medical Staff and the Hospital;

(5) may refer patients to members of the Medical Staff for admission and care;

(6) are encouraged to communicate directly with members about the care of any patients referred, as well as to visit any such patients;

(7) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(8) may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical record;

(9) are not granted inpatient or outpatient clinical privileges and, therefore, may not admit patients, attend patients, write orders for inpatients, perform consultations, assist in surgery, or otherwise participate in the management of clinical care to patients at the Hospital;

(10) may refer patients to the Hospital's diagnostic facilities and order such tests;

(11) are encouraged to accept referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department; and

(12) shall pay application fees, dues, and assessments.

(b) The grant of appointment to the Affiliate Staff is a courtesy only, which may be terminated by the Governing Board upon recommendation of the Medical Executive Committee, with no right to a hearing or appeal.

Part F. Honorary Staff:

Section 1. Qualifications:

(a) The Honorary Staff will consist of members of the Medical Staff who:

(1) Have a record of previous long-standing service to the Hospital, have retired from the active practice of medicine; and, in the discretion of the Medical Executive Committee, are in good standing at the time of initial application for membership on the Honorary Staff; or

(2) Are recognized for outstanding or noteworthy contributions to the medical sciences.

(b) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application.

Section 2 Prerogatives and Responsibilities:

Honorary Staff Members:

(a) May not consult, admit, or attend to patients;

(b) May attend Medical Staff and department meetings when invited to do so (without vote);

(c) May not hold office or serve as department chair or committee chair;

(d) Are entitled to attend educational programs of the Medical Staff and the Hospital; and

(e) Are not required to pay application fees, dues, or assessments.

ARTICLE IV

STRUCTURE OF THE MEDICAL STAFF

Part A. General:

Section 1. Medical Staff Year:

For the purpose of these Bylaws the Medical Staff year commences on the 1st day of July and ends on the 30th day of June each year.

Section 2. Dues:

All persons appointed to the Medical Staff, except Affiliate and Honorary Staff appointees, shall pay annual staff dues as may be recommended by the Medical Executive Committee and

approved by the Board from time to time. Signatories to this account shall be the President and the Secretary-Treasurer of the Medical Staff.

Section 3. Officers:

The officers of the Medical Staff shall be the President, Vice President and Secretary-Treasurer. Each officer shall serve a term of two (2) years, and may serve a maximum of one (1) term (2 years). Any officer who has served the maximum term of two (2) years in that office shall not be eligible again for election to that same office for a period of three (3) years. In special circumstances, the maximum term limit for an officer may be waived by the Nominating Committee with the approval of the Medical Executive Committee.

Section 4. Qualifications of Officers and Chairpersons:

Only those Active Staff appointees who satisfy the following criteria shall be eligible to serve as Medical Staff officers, clinical department chairpersons and committee chairpersons:

(a) be appointed in good standing to the Active Staff of the Hospital and continue to do so during their term of office. Medical Staff officers shall be non-podiatrist Active Staff members for at least five (5) years;

(b) have no pending adverse recommendations concerning staff appointment or clinical privileges;

(c) not be presently serving as a Medical Staff officer or Board member at another hospital, and shall not so serve during the term of office;

(d) have experience in a leadership position such as membership on a Medical Staff committee, or other involvement in performance improvement functions for at least two years;

(e) are encouraged to attend continuing education relating to Medical Staff leadership and/or credentialing functions prior or during the term of office;

(f) be willing to discharge faithfully the duties and responsibilities of the position; and

(g) have demonstrated an ability to work well with others.

In exceptional circumstances, the Medical Executive Committee may grant a waiver of one or more of the above eligibility criteria. In making a determination to grant a waiver, the Medical Executive Committee may consider the specific qualifications of the individual in question, input from Medical Staff leadership, the willingness of other practitioners to serve in the leadership position, and the best interests of the Hospital and Medical Staff. No individual is entitled to a waiver or to a hearing if the Medical Executive Committee determines not to grant a waiver. No physician shall simultaneously hold two officer positions.

Section 5. President of the Medical Staff:

The President shall:

(a) act in coordination and cooperation with the CEO, CPE, and Governing Board in matters of mutual concern involving the care of patients in the Hospital;

(b) call, preside at and be responsible for the agenda of all regular and special meetings of the Medical Staff;

(c) make recommendations for appointment of committee chairpersons and members, to all standing and special Medical Staff committees, except the Medical Executive Committee, in accordance with the provisions of these Bylaws;

(d) serve as Chairperson of the Medical Executive Committee and *ex officio* member, without vote, on all Medical Staff committees, except the Medical Executive Committee;

(e) represent the views, policies, needs and grievances of the Medical Staff and report on the medical activities of the staff to the Board and to the CEO;

(f) receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide medical care; and

(g) perform all other functions as may be authorized in these Bylaws and other applicable policies.

Section 6. Vice President of the Medical Staff:

The Vice President shall:

(a) assume all the duties and have the authority of the President of the Medical Staff in the event of the President's temporary inability to perform due to illness, absence from the community or unavailability for any other reason;

(b) serve on the Medical Executive Committee;

(c) automatically succeed the President should the office of President become vacated for any reason during the President's term of office; and

(d) perform such duties as are assigned by the President, the Medical Executive Committee or the Board.

Section 7. Secretary-Treasurer:

The Secretary-Treasurer shall:

(a) be a member of the Medical Executive Committee;

(b) cause to be kept accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings;

(c) collect staff dues and funds, and make disbursements authorized by the Medical Executive Committee or its designee;

(d) call meetings on order of the President of the Medical Staff; and

(e) attend to all correspondence and perform such other duties as pertain to the office of Secretary-Treasurer.

Section 8. Immediate Past President:

The Immediate Past President shall:

(a) serve on the Medical Executive Committee and Credentials Committee; and

(b) perform such additional or special duties as shall be assigned by the President of the Medical Staff, the Medical Executive Committee or the Board.

Section 9. Election of Officers:

(a) Nominating Committee:

The President of the Medical Staff shall appoint a Nominating Committee to present a slate of officers for election at least 30 days prior to the Annual Medical Staff meeting. There shall be at least three members on a Nominating Committee, each from a different Department. The members of the Nominating Committee shall be members of the Active Staff. This Committee shall offer in writing at least one or more nominees for each office.

(b) Nomination and Election of Officers:

(1) The Nominating Committee shall prepare a slate of nominees in consultation with Hospital administration for each office on the Medical Executive Committee to be filled at that election.

(2) Nominations for officers of the Medical Staff shall be presented by the Nominating Committee and by any other Medical Staff appointee prior to

each annual meeting. Any nomination made by an appointee other than the Nominating Committee must be submitted, in writing, to the Nominating Committee at least three (3) days prior to the election. In order to be included on the ballot as a candidate, each nominee must possess all the qualifications set forth in Article IV, Part A, Section 4.

(3) The candidates who receive a majority vote of those Medical Staff appointees eligible to vote and present at the meeting at the time the vote is taken shall be elected. The Medical Executive Committee will determine the mechanisms by which votes may be cast. The mechanisms that may be considered include written ballots and electronic voting via computer, fax, or other technology for transmitting the member's voting choices. Proxy voting shall not be permitted. The election of each officer shall become effective at the start of the next Medical Staff year and shall be for a term of one (1) year.

(4) In any election, if there are three (3) or more candidates for an office and no candidate receives a majority vote there shall then be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one (1) candidate.

Section 10. Removal of Officers:

The Medical Executive Committee, by a two-thirds vote, may remove any Medical Staff officer for failure to fulfill the responsibilities of the office, for conduct detrimental to the interests of the Hospital, or if the officer is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office, provided that notice of the meeting at which such action shall be decided is given in writing to such officer at least ten (10) days prior to the date of the meeting. The officer shall be afforded the opportunity to speak prior to the taking of any vote on such removal.

Section 11. Vacancies in Office:

If there is a vacancy in the office of the President of the Medical Staff prior to the expiration of the President's term, the Vice President shall assume the duties and authority of the President for the remainder of the unexpired term. If there is a vacancy in any other office, the Medical Executive Committee shall appoint another appointee possessing the qualifications set forth in Article IV, Part A, Section 4 to serve out the remainder of the unexpired term.

Part B. Clinical Departments:

Section 1. Organization of Departments:

The Medical Staff shall be organized in to the following departments:

(a) Medicine Department, including:

(1) Family Medicine

(2) Internal Medicine, including but not limited to:

(i) Dermatology

(ii) Endocrinology

(iii) Gastroenterology (“GI”)

(iv) General Medicine

(v) Hematology/Oncology

(vi) Nephrology

(vii) Pulmonary Disease

(viii) Rheumatology

(b) Surgery Department, including:

(1) Dental/Oral Surgery

(2) General Surgery, including the clinical specialty of Plastic Surgery

(3) Ophthalmology

(4) Orthopedics/Podiatry

(5) Otolaryngology/Head and Neck Surgery

(6) Urology

(c) Womens and Infants Department, including:

(1) Obstetrics and Gynecology
(“OB/GYN”)

(2) Pediatrics

(d) Cardiovascular Medicine, including:

(1) Cardiology

(2) Cardiothoracic Surgery

(e) Neurosciences Department, including:

(1) Neurosurgery

(2) Neurology

(3) Physiatry

(4) Psychiatry

(5) Pain Management

(f) Emergency Medicine Department

(g) Pathology Department

(h) Anesthesia Department

(i) Radiology Department; including:

(1) Radiology

(2) Radiation Oncology

Section 2. Assignment to Departments:

(a) Upon initial appointment to the Medical Staff, each member will be assigned to a clinical department. Assignment to a particular department does not preclude an individual from seeking and being granted clinical privileges typically associated with another department.

(b) An individual may request a change in department assignment to reflect a change in the individual's clinical practice.

Section 3. Functions of Clinical Departments:

The departments are organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the department; (ii) to monitor the practice of individuals with clinical privileges in a given department; and (iii) to provide appropriate specialty coverage in the Emergency Department, consistent with the provisions of these Bylaws and related documents. Departments may utilize sections, committees or service lines to facilitate compliance with department functions.

Section 4. Creation or Dissolution of Departments

(a) Clinical departments shall be created and may be consolidated or dissolved by the Medical Executive Committee upon approval by the Board as set forth below.

(b) The following factors shall be considered in determining whether a clinical department should be created:

(1) there exists a number of Medical Staff members who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department (this number must be sufficiently large to enable the department to accomplish its functions as set forth in these Bylaws);

(2) the level of clinical activity that will be affected by the new department is substantial enough to warrant imposing the responsibility to accomplish functions on a routine basis;

(3) a majority of the voting members of the proposed department vote in favor of the creation of a new department;

(4) it has been determined by the Medical Staff leadership and the Chief Executive Officer that there is a clinical and administrative need for a new department; and

(5) the voting Medical Staff members of the proposed department have offered a reasonable proposal for how the new department will fulfill all of the designated responsibilities and functions, including, where applicable, meeting requirements.

(c) The following factors shall be considered in determining whether the dissolution of a department is warranted:

(1) there is no longer an adequate number of Medical Staff members in the department to enable it to accomplish the functions set forth in these Bylaws;

(2) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department;

(3) the department fails to fulfill all designated responsibilities and functions, including, where applicable, its meeting requirements;

(d) no qualified individual is willing to serve as chairperson of the department; or

(e) a majority of the voting members of the department vote for its dissolution.

Section 5. Chairs and Vice Chairs:

(a) Each chair and vice chair will:

(1) be an Active Staff member;

(2) be certified by an appropriate specialty board or possess comparable competence as determined through the credentialing and privileging process;

(3) satisfy the eligibility criteria in Article IV, Part A, Section 4.

Section 6. Selection and Term of Chairs and Vice Chairs:

(a) Each chair and vice chair will be elected for a term of two (2) years by a majority vote of those department members eligible to vote in each department respectively.

(b) These recommendations will be reviewed by the Medical Executive Committee and will be forwarded to the Board for final action.

Section 7. Removal of Chairs and Vice Chairs:

(a) Removal of a chair or vice chair may be effectuated by a two-thirds vote of the department or a three-fourths vote of the Medical Executive Committee or by the Board for:

(1) failure to comply with the Bylaws, applicable policies, or Rules and Regulations;

(2) failure to perform the duties of the position held;

(3) conduct detrimental to patients or the interests of the Hospital and/or it's Medical Staff;

(4) an infirmity that renders the individual incapable of fulfilling the duties of that office; or

(5) failure to continue to satisfy any of the criteria in Article IV, Part A, Section 4.

(b) Prior to scheduling a meeting to consider removal, a representative from the department, Medical Executive Committee, or Board will meet with and inform the individual of the reasons for the proposed removal proceedings.

(c) The individual will be given at least ten days' special notice of the date of the meeting at which removal is to be considered. The individual will be afforded an opportunity to address the department, the Medical Executive Committee, or the Board, as applicable, prior to a vote on removal.

(d) Removal will be effective when approved by the Board.

Section 8. Duties of Chairs:

Each chair is responsible for the following functions, either individually or in collaboration with Hospital personnel. These functions may be delegated to specialties within the department. Specialties may elect a chair and vice chair.

(a) all clinically-related activities of the department;

(b) all administratively-related activities of the department, unless otherwise provided for by the Hospital;

(c) continuing surveillance of the professional performance of individuals in the department who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations;

(d) recommending criteria for clinical privileges that are relevant to the care provided in the department with input from the applicable specialty;

(e) Evaluating requests for clinical privileges for each Member of the department;

(f) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital;

(g) the integration of the department into the primary functions of the Hospital;

(h) the coordination and integration of interdepartmental and intradepartmental services;

(i) the development and implementation of policies and procedures that advance quality and that guide and support the provision of care, treatment, and services;

(j) recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

(k) determination of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(l) continuous assessment and improvement of the quality of care, treatment, and services provided;

(m) maintenance of quality monitoring programs, as appropriate;

(n) the orientation and continuing education of Members of the department;

(o) recommendations for space and other resources needed by the department; and

(p) performing functions authorized in these Bylaws, including collegial intervention efforts.

Part C. Meetings of the Medical Staff:

Section 1. Medical Staff Meeting:

The Medical Staff shall hold a regular staff meeting annually on a date set by the President of the Medical Staff at which officers and any members at-large of the Medical Executive Committee shall be elected. This regular staff meeting shall also be for the purpose of reviewing and evaluating clinical department and committee reports and recommendations, and to act on any other matters placed on the agenda by the President.

Section 2. Special Staff Meetings:

Special meetings of the Medical Staff may be called at any time by the Board, the President of the Medical Staff, a majority of the Medical Executive Committee, or by the President of the Medical Staff based on a petition signed by not less than ten (10) percent of the voting staff. In the event that it is necessary for the staff to act on a question without being able to meet, the voting staff may be presented with the question by mail and their votes returned to the President of the Medical Staff by mail. Such a vote shall be valid so long as the question is voted on by a majority of the staff eligible to vote.

Section 3. Quorum:

The presence of one-fourth of the persons eligible to vote shall constitute a quorum for any regular or special meeting of the Medical Staff. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

Section 4. Agenda:

The agenda at any regular or special Medical Staff meeting and its conduct shall be set by the President of the Medical Staff.

Part D. Medical Staff Committees and Functions:

Section 1. Regular Clinical Department Meetings:

Clinical departments shall meet as often as necessary to fulfill their responsibilities, but at least quarterly (four (4) times per year), on dates and at a time set by the clinical department chairperson at the beginning of the Medical Staff year. The purpose of these meetings shall be to review and evaluate the clinical work of the department, to consider the findings of ongoing quality assessment, monitoring and evaluation activities, and to discuss any other matters concerning patient care and activities of the clinical department. The agenda for the meeting and its general conduct shall be set by the clinical department chairperson. Each clinical department shall maintain a permanent record of its findings, proceedings and actions, and shall make a report after each meeting to the Medical Executive Committee and the CEO.

Section 2. Committee Meetings:

(a) All committees shall meet at least quarterly (four (4) times per year), unless otherwise specified in these Bylaws. The agenda for the meeting and its general conduct shall also be set by the committee chairperson.

(b) All committee chairpersons shall have the authority to convene their committees for special meetings as needed, in addition to those regular meetings required by these Bylaws. The notice requirements set forth in these Bylaws shall apply.

Section 3. Special Meetings:

(a) A special meeting of any clinical department or committee may be called by or at the request of the appropriate chairperson, the President of the Medical Staff, the Board, or shall be called by the chairperson within ten (10) days after receipt of a petition signed by not less than twenty percent (20%) of the members of the clinical department or committee. No business shall be transacted at any special meeting except that stated in the meeting notice.

(b) In the event that it is necessary for a clinical department or committee to act on a question without being able to meet, the voting members may be presented with the question, in person or by mail, and their vote returned to the clinical department chairperson or committee chairperson. Such a vote shall be binding so long as the question is voted on by a majority of the members eligible to vote.

Section 4. Quorum:

The presence of twenty-five percent (25%) of the total membership of the clinical department or committee eligible to vote at any regular or special meeting (but in no event less than three (3) members) shall constitute a quorum. *Ex officio* members shall not be counted in determining the presence of a quorum. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

Section 5. Minutes:

Minutes of all meetings of clinical departments and committees shall be prepared and shall include a record of the attendance of members, a summary of recommendations made, and the votes taken on each matter. The minutes shall be reviewed and signed by the presiding officer and copies shall be promptly forwarded to the Medical Executive Committee, the Secretary-Treasurer of the staff, and, at the same time, to the CEO and certain committees as specified elsewhere in these Bylaws. A permanent file of all minutes shall be maintained by the Hospital.

Section 6. Creation of Standing Committees:

(a) The Medical Executive Committee may, by resolution and upon approval of the Board, without amendment of the Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the Medical Executive Committee may, by resolution and upon approval of the Board, dissolve or rearrange committee structure, duties or composition as needed to better accomplish Medical Staff functions.

(b) The Medical Executive Committee, without the approval of the Medical Staff, may establish ad hoc committees with specific duties for the purpose of assisting the Medical Staff in its determination to establish a standing committee to perform the duties performed by the ad hoc committee.

(c) Additional performance improvement panels may be established by the Performance Improvement Committee upon approval of the Medical Executive Committee, or by the Medical Executive Committee, without the approval of the Medical Staff.

(d) Any function required to be performed by the Bylaws which is not assigned to a standing or special committee shall be performed by the Medical Executive Committee.

Section 7. Special Committees:

Special committees shall be created, and their members and chairpersons shall be appointed, by the President of the Medical Staff with the approval of the Board as required. The functions and activities of special committees may include, but shall not be limited to, such areas as medical library, rehabilitation and critical care services. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Medical Executive Committee.

Part E. Provisions Common to all Meetings:

Section 1. Prerogatives of the Presiding Officer:

(a) The Presiding Officer/designee of each meeting is responsible for setting the agenda for any regular or special meeting of the Medical Staff, department, or committee.

(b) The Presiding Officer has the discretion to conduct any meeting by telephone conference or videoconference.

(c) The Presiding Officer shall have the authority to rule definitively on all matters of procedure. While Robert's Rules of Order may be used for reference, in the discretion of the Presiding Officer, it shall not be binding. Rather, specific provisions of these Bylaws and Medical Staff, department, or committee custom shall prevail at all meetings and elections.

Section 2. Notice of Meetings:

Notice of all meetings of the Medical Staff and regular meetings of clinical departments and committees shall, unless held pursuant to a resolution, be posted on an electronic information system or delivered, either in person or by mail, to each person entitled to be present at such meetings not less than three (3) or more than thirty (30) working days in advance of such meetings. The notice shall state the date, time and place of the meeting. When mailed, the notice shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each person at his/her address as it appears on the records of the Hospital. Such posting and mailing shall be deemed to constitute actual notice to the persons concerned. The attendance of any person at any meeting shall constitute a waiver of notice of such meeting.

Section 3. Attendance Requirements:

(a) Each Active Staff appointee shall be required to attend general Medical Staff meetings in each year unless excused.

(b) An appointee who is compelled to be absent from any general Medical Staff meeting shall notify the Medical Staff Office of the reason for such absence. Failure to meet the foregoing attendance requirements will be considered at the time of an individual's request for reappointment to the staff, unless the clinical department or committee chairperson finds that the absences are valid.

Section 4. Special Appearance:

(a) Whenever apparent or suspected deviation from standard clinical practice is involved, special notice of the time and place of the meeting shall be given at least five (5) days prior to the meeting and shall include a statement of the issue involved and that the appointee's attendance is mandatory.

(b) The failure of an individual to attend a conference to which notice was given that attendance was mandatory shall be reported to the Medical Executive Committee. Unless excused by the Medical Executive Committee upon showing of good cause,

such failure shall result in automatic relinquishment of all or such portion of the individual's clinical privileges as the Medical Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved.

Section 5. Rules of Order:

Wherever they do not conflict with these Bylaws, the currently revised Robert's Rules of Order shall govern all meetings and elections.

Section 6. Voting:

Any individual who, by virtue of position, attends a meeting in more than one (1) capacity shall be entitled to only one (1) vote.

ARTICLE V

COMMITTEES OF THE MEDICAL STAFF

Part A. Appointment:

Section 1. Chairpersons:

(a) All committee chairpersons, unless otherwise provided for in these Bylaws, shall be appointed by the Board upon recommendations from the President of the Medical Staff. All chairpersons shall be selected based on the criteria set forth in Article IV, Part A, Section 4 of these Bylaws. Such appointments will be made by the Board, at its first meeting after the end of the Medical Staff year, for an initial term of one (1) year.

(b) After serving an initial term, a chairperson may be reappointed by the Board from year to year, upon recommendation from the President of the Medical Staff and the CEO.

Section 2. Members:

(a) Except as otherwise provided for in these Bylaws, members of each committee shall be appointed annually by the President of the Medical Staff, in consultation with the CEO, not more than thirty (30) days after the regular meeting of the Medical Staff, and there shall be no limitation in the number of terms they may serve. All appointed members may be removed and vacancies filled at the discretion of the President of the Medical Staff.

(b) The CEO, CPE and the President of the Medical Staff or their respective designees shall be members, *ex officio*, without vote, on all committees, unless otherwise specified in these Bylaws.

(c) The secretary of each committee shall be appointed by the chairperson of the committee, unless otherwise provided in these Bylaws.

Part B. Medical Executive Committee:

Section l. Composition:

(a) The Medical Executive Committee shall consist of the three (3) elected officers of the Medical Staff, the Immediate Past President of the Medical Staff, and the chairperson of each clinical department. The Chairperson of the Credentials Committee, the Chairperson of the Performance Improvement Committee or designee, the CEO, the Program Director of the Family Medicine Residency Training Program, the Chief Physician Executive and the Chief Medical Information Officer shall serve as *ex officio* members, without vote.

(b) The President of the Medical Staff shall be Chairperson of the Medical Executive Committee.

(c) The Chairperson of the Board may attend meetings of the Medical Executive Committee and participate in its discussions, but without vote.

Section 2. Medical Executive Committee Duties:

The Medical Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and performance improvement activities regarding the professional services provided by individuals with clinical privileges. The Medical Executive Committee is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between Medical Executive Committee meetings);

(b) recommending directly to the Board on at least the following:

(1) the Medical Staff's structure;

(2) the mechanism used to review credentials and to delineate individual clinical privileges;

(3) applicants for Medical Staff appointment and reappointment;

(4) delineation of clinical privileges for each eligible individual;

(5) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

(6) the mechanism by which Medical Staff appointment may be terminated;

(7) hearing procedures;

(8) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate.

(c) consulting with administration on quality-related aspects of contracts for patient care services;

(d) providing oversight and guidance with respect to continuing medical education activities;

(e) reviewing or delegating the review of quality indicators to facilitate uniformity regarding patient care services;

(f) providing leadership in activities related to patient safety;

(g) providing oversight in the process of analyzing and improving patient satisfaction;

(h) prioritizing continuing medical education activities;

(i) ensuring that, at least every three years, the Bylaws, policies, Rules and Regulations, and associated documents of the Medical Staff are reviewed and updated;

(j) providing and promoting effective liaison among the Medical Staff, Management, and the Board;

(k) recommending clinical services, if any, to be provided by telemedicine;

(l) reviewing and approving all standing orders for consistency with nationally recognized and evidence-based guidelines; and

(m) performing any other functions as are assigned to it by these Bylaws or other applicable policies.

Section 3. Meetings, Reports and Recommendations:

(a) The Medical Executive Committee shall meet at least once each month or more often if necessary to transact pending business. The Secretary-Treasurer will maintain reports of all meetings, which reports shall include the minutes of the various committees and clinical departments of the staff. Copies of all minutes and reports of the Medical Executive Committee shall be transmitted to the CEO routinely as prepared. Recommendations of the Medical Executive Committee

shall be transmitted to the Board with a copy to the CEO. The Chairperson of the Medical Executive Committee shall be available to meet with the Board or its applicable committee on all recommendations that the Medical Executive Committee may make.

(b) Between meetings of the Medical Executive Committee, an ad hoc committee composed of the officers of the staff and the Chairperson of the Credentials Committee shall be empowered to act in situations of urgent or confidential concern where not prohibited by these Bylaws.

Part C. Performance Improvement and Review Functions of Medical Staff Committees:

1. The Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following:

(a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals and reduce patient safety risks;

(b) the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(c) medical assessment and treatment of patients;

(d) medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

(e) the utilization of blood and blood components, including review of significant transfusion reactions;

(f) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(g) education of patients and families;

(h) coordination of care, treatment and services with other practitioners and Hospital personnel;

(i) accurate, timely and legible completion of medical records;

(j) the required content and quality of history and physical examinations, as well as the time frames required for completion;

(k) the use of developed criteria for autopsies;

(l) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(m) healthcare associated infection;

(n) unnecessary procedures or treatment;

(o) appropriate resource utilization:

(p) appropriateness of clinical practice patterns;

(q) significant departures from established patterns of clinical practice;

(r) the use of information about adverse privileging determinations regarding any practitioner;

(s) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and

(t) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Board.

2. A description of other Medical Staff committees that perform peer review, systematic monitoring and performance improvement activities, and other review functions delegated to the Medical Staff by the Board are set forth in these Bylaws and/or the Committee Manual.

Part D. Credentials Committee:

Section 1. Composition:

(a) The Credentials Committee shall be a standing committee of the Medical Staff and shall consist of at least seven (7) appointees, including at least one (1) representative from each clinical department, and at least two (2) at-large members of the Medical Staff selected by the President of the Medical Staff, and the Immediate Past President of the Medical Staff. The Chairperson and Vice Chair of the Committee shall be selected by the Committee. Service on this committee shall be considered a primary Medical Staff obligation of each member of the committee and other Medical Staff duties shall not interfere. If at any time the continued workability of the committee is threatened by the inability or unwillingness of any of the individuals to serve, the President of the Medical Staff shall appoint up to five (5) additional members to the committee, for terms of one (1) year each, to fill the vacancies.

(b) Members of the Credentials Committee shall serve for three (3) years with staggered terms, with no limitation on the number of terms they may serve.

Section 2. Duties:

The duties of the Credentials Committee shall be:

(a) to review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, to make investigations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations to the Medical Executive Committee; and

(b) to review, as requested by the Medical Executive Committee, information regarding the clinical competence and behavior of persons currently appointed to the Medical Staff and of those practicing as allied health professionals and, as a result of such review, to make a written report of its findings and recommendations to the Medical Executive Committee.

Section 3. Meetings, Reports and Recommendations:

The Credentials Committee shall meet as often as necessary to accomplish its duties, but at least quarterly, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Medical Executive Committee, the CEO and the Board. The Chairperson of the Credentials Committee shall be available to meet with the Board or the Executive Committee of the Board on all recommendations that the Credentials Committee may make.

Part E. Bylaws Committee:

Section 1. Composition:

The Bylaws Committee shall be a standing committee of the Medical Staff and shall consist of the Vice President of the Medical Staff, at least five (5) Active Staff appointees, and one (1) representative from Hospital administration appointed by the CEO.

Section 2. Duties:

The Bylaws Committee shall:

(a) review the Bylaws of the Medical Staff, the Medical Staff Rules and Regulations, and other Medical Staff associated documents at least annually and recommend amendments as appropriate to the Medical Executive Committee; and

(b) receive and consider all recommendations for changes in these documents made by the Board, any Medical Staff committee or clinical department, any individual appointed to the Medical Staff, and the CEO.

Section 3. Meetings, Reports and Recommendations:

The Bylaws Committee shall meet as often as necessary to fulfill its duties, but at least annually, and shall make a written report of its findings, proceedings, actions, and recommendations after each meeting to the Executive Committee and the CEO.

ARTICLE VI

APPOINTMENT TO THE MEDICAL STAFF

Part A. Qualifications for Appointment:

Section 1. General:

(a) Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in these Bylaws and in such policies as are adopted from time to time by the Board.

(b) To be eligible to apply for appointment to the Medical Staff, physicians and dentists and podiatrists must:

(1) have a current, unrestricted license to practice in the State of Wisconsin;

(2) have a current, unrestricted DEA registration and state controlled substance license, as applicable;

(3) be located (office and residence) within the geographic service area of the Hospital as defined by the Board, close enough to provide timely and continuous care for their patients in the Hospital;

(4) possess a current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital and from a carrier acceptable to the Board, or other evidence of financial responsibility satisfactory to the Board;

(5) not be currently excluded or precluded from participation in any government health program;

(6) have successfully completed an accredited ACGME/AOA residency training program of at least three (3) years, in the specialty in which the applicant seeks clinical privileges, or a dental surgery training program accredited by the American Association of Oral and Maxillofacial Surgery and/or the Commission on Dental Education of the American Dental Association, or a podiatric surgical residency program accredited by the Council on Podiatry Education of the American Podiatry Association. The requirement for residency training as set forth in these Bylaws shall be waived for all Medical Staff appointees who held clinical privileges at this

Hospital without residency training certification on or before January 10, 2001;

(7) be certified by the appropriate specialty board of the American Board of Medical Specialties or the appropriate specialty board of the American Osteopathic Association ("AOA") or the Royal College of Physicians and Surgeons of Canada, unless such requirement is waived by the Board after considering the specific competence and experience of the individual in question;

(8) become certified by the appropriate specialty board within five (5) years of completion of the residency training in the specialty or subspecialty area in which clinical privileges are requested, unless such requirement is waived by the Board after considering the specific competence, training, and experience of the individual in question, or waived by the Board for those applicants and appointees who practice in medical subspecialties where there are specific practice prerequisites for admissibility to board examination.

(i) Dentist applicants and appointees requesting surgical privileges must be certified or admissible to examination for certification by the American Board of Oral and Maxillofacial Surgery; and

(ii) Podiatrist applicants and appointees must be certified or admissible to examination for certification by the American Board of Podiatric Surgery;

(9) maintain board certification to the extent required by the applicable specialty/subspecialty board, and satisfy recertification requirements. Recertification status will be assessed at reappointment; and

(10) demonstrate recent clinical activity in their primary area of practice during the last two (2) years.

(c) The requirement for board certification as set forth in these Bylaws shall be waived for all Medical Staff appointees who held specialty or subspecialty clinical privileges at this Hospital on or before January 10, 2001.

Section 2. Documentation:

To be qualified for appointment consideration, applicants must document their:

(a) background, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;

(c) good reputation and character;

(d) ability to perform the clinical privileges requested safely and competently;

(e) ability to work cooperatively and harmoniously, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families and other members of health care teams, so that all patients treated by them at the Hospital will receive quality care and the Hospital and its Medical Staff will be able to operate in an orderly manner;

(f) recognition of the importance of, and willingness to support, the Hospital's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care; and

(g) demonstration of commitment to quality as reflected by objective data measures.

Section 3. Waiver of Requirement:

(a) Any individual who does not satisfy one or more of the criteria outlined above may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the individual in question, input from the relevant department chairman (or supervisor), and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation shall be forwarded to the Medical Executive Committee for final determination. Any recommendation to grant a waiver must include the basis for such.

(c) The Medical Executive Committee will inform the Governing Board that a waiver was granted when the application is submitted to the Governing Board for approval.

(d) No individual is entitled to a waiver or to a hearing if the Medical Executive Committee or Governing Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.

(e) The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

(f) An application for appointment that does not satisfy an eligibility criterion shall not be processed until the Medical Executive Committee has determined that a waiver should be granted.

Section 4. No Entitlement to Appointment:

No individual shall be entitled to appointment to the Medical Staff or to exercise particular clinical privileges in the Hospital merely because he or she:

(a) is licensed to practice a profession in this or any other state;

(b) is a member of any particular professional organization;

(c) is certified by any medical specialty board;

(d) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or other health care facility;

(e) resides in the geographic service area of the Hospital; or

(f) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

Section 5. Non-Discrimination:

No individual shall be denied appointment on the basis of sex, race, creed, religion, color or national origin, or on the basis of any criteria unrelated to the delivery of quality patient care at the Hospital, to professional qualifications, or to the Hospital's purposes, needs and capabilities.

Section 6. Ethical and Religious Directives:

All Medical Staff appointees and others exercising clinical privileges in the Hospital shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops with respect to their practice at the Hospital. No activity prohibited by said Directives shall be engaged in by any Medical Staff appointee or other person exercising clinical privileges or a scope of practice at the Hospital.

Part B. Conditions of Appointment:

Section 1. Duties of Appointees:

Appointment to the Medical Staff shall require that each appointee assume such reasonable duties and responsibilities as the Medical Staff or the Board shall require.

Section 2. Professional Conduct:

Individuals appointed to the Medical Staff shall be expected to relate in a positive and professional manner to other health care professionals, and to cooperate and work collegially with the Medical Staff leadership and Hospital management and personnel. Professional conduct shall also include, but not be limited to, each appointee's obligation to present himself or herself at the Hospital physically and mentally capable of providing safe and competent care to patients.

Part C. Application for Initial Appointment and Clinical Privileges:

Section 1. Request for Application:

(a) An individual requesting an application for appointment to the Medical Staff shall be told by the Medical Staff Office that an application will only be forwarded to those individuals who can document that they meet all of the eligibility criteria set forth in Article VI, Part A, Section 1, who desire to provide care and treatment to patients for conditions and diseases for which the Hospital has facilities and personnel, and who indicate an intention to use the Hospital as required by the staff category to which they desire appointment.

(b) An individual requesting an application for appointment shall initially be sent a letter that outlines the eligibility criteria for appointment and the applicable criteria for clinical privileges consideration.

(c) Those individuals who meet the eligibility criteria for consideration for appointment to the Medical Staff and clinical privileges shall be given an application. Individuals who fail to meet the threshold criteria shall not be given an application and shall be notified that they are ineligible to apply. There is no right to a hearing on a determination of ineligibility.

(d) A completed application form with copies of all required documents must be returned to the Medical Staff Office within 90 days. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold criteria shall be notified that their applications shall not be processed.

(e) The issuance of an application does not indicate or guarantee that the application or any privileges shall be recommended or granted.

Section 2. Information:

(a) Applications for appointment to the Medical Staff shall be submitted on a form approved by the Board upon recommendation of the Credentials and Medical Executive Committees and obtained from the Medical Staff Office. The application shall include the payment of such processing fees as may be recommended by the Medical Executive Committee and approved by the Board.

(b) The application shall contain a request for specific clinical privileges and shall require detailed information concerning the applicant's professional qualifications including:

(1) the names and complete addresses of at least two (2) physicians, dentists, podiatrists or other practitioners, as appropriate, who have had extensive experience in observing and working with the applicant, and who can provide adequate information pertaining to the applicant's present professional competence and character. References may not be from individuals about to be associated with the applicant in professional practice or personally related to the applicant. At least one (1) reference shall be from the same specialty area as the applicant;

(2) the names and complete addresses of the individuals who served as chiefs or chairpersons at the time the applicant worked in the particular department of any and all hospitals or other institutions. If the number of hospitals the applicant has worked in is great or if a number of years have passed since the applicant worked at a particular hospital, the Credentials Committee (and Medical Executive Committee) and the Board may take into consideration such factors;

(3) information as to whether the applicant's Medical Staff appointment or clinical privileges have ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subject to probationary or other conditions, reduced or not renewed at any other hospital or health care facility;

(4) information as to whether the applicant has ever voluntarily or involuntarily withdrawn an application for appointment, reappointment and clinical privileges, not including a voluntary personal decision by the applicant to request a lesser scope of clinical privileges upon reappointment or during the term of appointment, or resigned from the Medical Staff before final decision by a hospital's or health care facility's governing board;

(5) information as to whether the applicant's license to practice any profession in any state, or Drug Enforcement Administration license is or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted or is currently being challenged;

(6) documentation concerning the applicant's current professional liability insurance coverage, including the name of the insurance company, the amount and classification of such coverage, whether said insurance coverage covers the clinical privileges requested, and whether any restrictions have been imposed on the applicant's liability coverage;

(7) a consent to the release of information from the applicant's present and past professional liability insurance carriers;

(8) information concerning pending professional liability litigation, final judgments or settlements: (i) the substance of the allegations, (ii) the findings, (iii) the ultimate disposition, and (iv) any additional information the Credentials or Medical Executive Committees or the Board may deem appropriate;

(9) information concerning any professional misconduct proceedings and any malpractice actions involving the applicant in this state or any other state, and whether such proceedings are closed or still pending;

(10) information concerning the suspension or termination for any period of time in Medicare, Medicaid, any other government sponsored program, or any private or public medical insurance program, and information as to whether the applicant is currently under investigation;

(11) current information regarding the applicant's ability to exercise the privileges requested competently and safely and to perform the duties and responsibilities of appointment;

(12) information as to whether the applicant has ever been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to controlled substances, illegal drugs, Medicare, Medicaid or insurance or health care fraud or abuse, or violence;

(13) a complete chronological listing of the applicant's professional and educational appointments, employment, or positions;

(14) information on the citizenship or visa status of the applicant;

(15) the applicant's signature; and

(16) such other information as the Board may require.

(c) The history of malpractice verdicts and the settlement of malpractice claims, as well as pending claims, will be evaluated as a criterion for appointment, reappointment, and the granting of clinical privileges. However, the mere presence of verdicts, settlements or claims shall not, in and of themselves, be sufficient to deny

appointment or particular clinical privileges. The evaluation shall consider the extent to which verdicts, settlements or claims evidence a pattern of care that raises questions concerning the individual's clinical competence, or whether a verdict, settlement or claim in and of itself, represents such deviation from standard medical practice as to raise overall questions regarding the applicant's clinical competence, skill in the particular clinical privilege requested, or general behavior.

Section 3. Applicant's Signature:

The applicant's signature shall constitute agreement:

(a) that the applicant has received and had an opportunity to read a copy of the bylaws of the Hospital, and the Bylaws, Rules and Regulations of the Medical Staff, and agrees to be bound by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment to the Medical Staff and clinical privileges are granted;

(b) that any misrepresentation or misstatement in, or omission from, the application, whether intentional or not, shall result in no further processing. If appointment or reappointment has been granted prior to discovery of such misrepresentation, misstatement or omission, such discovery may result in automatic relinquishment of all clinical privileges and Medical Staff appointment. In either situation, there shall be no entitlement to any hearing or appeal;

(c) that the hearing and appeal procedures set forth in these Bylaws shall be the sole and exclusive remedy with respect to any professional review action taken at this Hospital;

(d) authorize the release of all information necessary for an evaluation of the individual's qualifications; and

(e) extend, to the fullest permitted by law, immunity to the Hospital, its Medical Staff and all individuals acting for the Hospital and/or its Medical Staff in matters relating to appointment, reappointment and clinical privileges.

Section 4. Basic Responsibilities and Requirements:

As a condition of consideration for appointment or reappointment, permission to practice or renewal of permission to practice, and as a condition of continued appointment or affiliation, every member specifically agrees to the following:

(a) to provide continuous and timely care and supervision of the generally, professionally recognized level of quality and efficiency to all patients in the Hospital for whom the individual has responsibility;

(b) to abide by all Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff in force during the time the individual is appointed;

(c) to attend medical staff orientation including training on the use of the electronic medical record prior to being allowed to exercise clinical privileges;

(d) to accept committee assignments, emergency service call obligations, care of unassigned patients, consultation requests, participation in quality improvement and peer review activities, and such other reasonable responsibilities as shall be assigned;

(e) to comply with clinical practice protocols and guidelines that are established by, and must be reported to, regulatory or accrediting agencies, or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the reasons for variance;

(f) to inform to the CEO, CPE and the President of the Medical Staff of any change in the practitioner's status or any change in the information provided on the individual's application form. This information shall be provided with or without request, at the time the change occurs, and shall include, but not be limited to, changes in licensure or certification status or professional liability insurance coverage, the filing of a lawsuit against the practitioner, changes in the practitioner's medical staff status at any other hospital, exclusion or preclusion from participation in Medicare or any other sanction(s) imposed, and any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment or affiliation because of health status issues, including impairment due to addiction;

(g) to appear, if requested, for personal interviews in regard to the application for initial appointment or reappointment;

(h) to comply with all medical staff policies and requirements regarding the use of electronic medical records;

(i) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(j) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(k) to refrain from deceiving patients as to the identity of any individual providing treatment or services;

(l) to seek consultation whenever necessary;

(m) to abide by generally recognized ethical principles applicable to the individual's profession;

(n) to participate in monitoring and evaluation activities;

(o) to complete in a timely manner all medical (including electronic) and other required records containing all information required by the Hospital;

(p) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;

(q) to pay promptly any applicable dues, assessments and/or fines;

(r) to satisfy continuing medical education requirements;

(s) to undergo a tuberculin test as a condition of initial appointment, and at reappointment as requested;

(t) to provide documented evidence of influenza vaccination status or reason for declination annually, as requested;

(u) to abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the Unites States Conference of Catholic Bishops, Washington, D.C., of the Roman Catholic Church and to refrain from performing any activity prohibited by said Directives;

(v) to immediately submit to a blood and/or urine test, or to a complete physical and/or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and one member of the Hospital administrative team) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leadership; and

(vw) to participate in an Organized Health Care Arrangement with the Hospital and to abide by the terms of the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital.

Section 5. Burden of Providing Information:

(a) The applicant shall have the burden of producing adequate information for a proper evaluation of competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications.

(b) The applicant shall have the burden of providing evidence that all the statements made and information given on the application are true.

(c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required will be deemed withdrawn.

(d) Applicants are responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

(e) Applicants are responsible for notifying the Credentials Committee (via the Medical Staff Office) of any change in status or any change in the information provided on the application form. This information is required to be provided with or without request, at the time the change occurs, and includes, but is not limited to:

(i) any information on the application form;

(ii) any threshold eligibility criteria for appointment or clinical privileges;

(iii) any and all complaints, documents or other information known to the practitioner regarding, or changes in, licensure status or DEA controlled substance authorization;

(iv) changes in professional liability insurance coverage;

(v) the filing of a professional liability lawsuit against the practitioner;

(vi) arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;

(vii) exclusion or preclusion from participation in Medicare, Medicaid or any other federal or state healthcare program or any sanctions imposed with respect to the same; and

(viii) any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health issues, including, but not limited to, impairment due to addiction.

Section 6. Immunity and Authorization to Obtain/Release Information:

By applying for appointment and reappointment, the applicant expressly accepts these conditions during the processing and consideration of the application, whether or not initial appointment, reappointment or clinical privileges are granted.

(a) Immunity:

To the fullest extent permitted by law, the applicant extends immunity to, releases from any and all liability and agrees not to sue the CVO, Hospital, any authorized representatives of the Hospital, or any third parties providing information to or receiving information from the Hospital.

This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Hospital, its representatives, or third parties in the course of credentialing and peer review activities or when using or disclosing information as described in this Section. Nothing herein shall be deemed to waive any other immunity or privilege provided by federal or state law.

(b) Use and Disclosure of Information:

(i) Information Defined:

For purposes of this Section, "information" means information about the individual, regardless of the form (which shall include verbal, electronic, and paper), which pertains to the individual's appointment, reappointment, clinical privileges, or scope of practice, or the individual's qualifications for the same, including, but not limited to:

(a) Information pertaining to the individual's clinical competence, professional conduct, character, reputation, ethics, and ability to practice safely with or without accommodation, and any other matter reasonably having a bearing on the individual's satisfaction of the criteria for initial and continued appointment to the Medical Staff;

(b) Any matters addressed on the application form or in the Medical Staff Bylaws, Hospital or Medical Staff policies and Rules and Regulations;

(c) Any reports about the individual which are made by the Hospital, its Medical Staff Leaders, or their representatives to the National Practitioner Data Bank or relevant state licensing boards/agencies; and

(d) Any references received or given about the individual.

(ii) Authorization for Criminal Background Check:

The individual agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

(iii) Authorization to Share Information within the System:

The individual authorizes the Hospital and its affiliates to share information with one another.

(iv) Authorization to Obtain Information from Third Parties:

The individual authorizes the CVO, Hospital, Medical Staff Leaders, and their representatives to request or obtain information from third parties and specifically authorizes third parties to release information to the Hospital.

(v) Authorization to Disclose Information to Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to disclose information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives to assist them in evaluating the individual's qualifications.

Part D. Procedure for Initial Appointment and Privileges:

Section 1. Submission of Application:

(a) After reviewing the application to determine that all questions have been answered, after reviewing all references and other information or materials deemed pertinent, after querying the National Practitioner Data Bank, and after verifying the information provided in the application with the primary sources, the Medical Staff Office shall transmit the complete application and all supporting materials to the appropriate clinical department chairperson for further evaluation.

(b) An application shall become incomplete if the need arises at any time for new, additional or clarifying information. Any application that continues to be incomplete thirty (30) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. The applicant shall be responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

Section 2. Clinical Department Chairperson Procedure:

(a) The clinical department chairperson or his/her respective designee of each clinical department in which the applicant seeks clinical privileges shall provide the Credentials Committee with a written report concerning the applicant's qualifications for the requested clinical privileges. As part of the process of making this report, the department chairperson or his/her respective designee shall discuss with the applicant (in person or by mail) any aspect of the application, qualifications and requested clinical privileges.

(b) The clinical department chairperson or other individual within the department to which the chairperson has assigned this responsibility, shall evaluate the applicant's education, training, experience and conduct and make inquiries with respect to the applicant's past or current department chairperson(s), residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(c) The clinical department chairperson shall be available to the Credentials Committee to answer any questions that may be raised with respect to their report and findings.

<u>Section 3. Credentials Committee Procedure</u>:

(a) The Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior and ethical standing and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including the report and findings from the clinical department chairperson of each clinical department in which privileges are sought, whether the applicant has established and satisfied all of the necessary qualifications for appointment and for the clinical privileges requested.

(b) As part of the process of making its recommendation, the Credentials Committee may meet with the applicant to discuss any aspect of the applicant's application, qualifications, and/or clinical privileges requested.

(c) The Credentials Committee may use the expertise of the clinical department chairperson, or any member of the clinical department, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(d) The name of the applicant shall be posted or circulated so that each Medical Staff appointee may have an opportunity to submit to the Credentials Committee, in writing, information bearing on the applicant's qualifications for staff appointment or clinical privileges. In addition, any current Medical Staff appointee shall have the right to appear in person before the Credentials Committee to discuss in private and in confidence any concerns the appointee may have about the applicant.

(e) After determining that the applicant is qualified for appointment and privileges, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Credentials Committee. The results of any examination shall be made available to the committee for its consideration. Failure of an applicant to undergo such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary withdrawal of the application and all processing of the application shall cease.

(f) If, after considering the report of the clinical department chairperson concerned, the Credentials Committee's recommendation for appointment is favorable, the

Credentials Committee shall recommend appointment and clinical department assignment. All recommendations to appoint must specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions as deemed appropriate by the committee.

(g) If the recommendation of the Credentials Committee is delayed longer than ninety (90) days, the Chairperson of the Credentials Committee shall send a letter to the applicant, with a copy to the Medical Executive Committee and CEO, explaining the reasons for the delay.

Section 4. Credentials Committee Report:

(a) Not later than ninety (90) days from its receipt of the application and all required and requested information, the Credentials Committee shall send its recommendation, written findings and all supporting documentation to the Medical Executive Committee.

(b) The Chairperson of the Credentials Committee shall be available to the Executive Committee (and to the Board or Medical Executive Committee of the Board) to answer any questions that may be raised with respect to the Credentials Committee's findings and recommendation.

Section 5. Medical Executive Committee and Board Procedure:

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:

(1) adopt the findings and recommendation of the Credentials Committee;

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or

(3) state in its report clear and convincing reasons for its disagreement with the Credentials Committee's recommendation. Thereafter, the Medical Executive Committee's recommendation shall be forwarded, together with the Credentials Committee's findings and recommendation, to the Board (or the Executive Committee of the Board).

(b) If the recommendation of the Medical Executive Committee is to appoint, the Medical Executive Committee shall transmit its recommendation for assignment and clinical privileges, including the report of the reviewing body, through the CEO to the Board (or the Executive Committee of the Board).

(c) If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing, it shall be forwarded to the CEO who shall promptly

notify the applicant by special notice. The CEO shall then hold the application until after the applicant has requested or waived a hearing and appeal as provided in these Bylaws. The CEO shall, thereafter, forward the recommendation of the Medical Executive Committee, together with the complete application and all supporting documentation to the Board (or the Executive Committee of the Board) for further action.

(d) Upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board (or the Executive Committee of the Board) may:

(1) appoint the applicant and grant clinical privileges as recommended; or

(2) refer the matter back to the Medical Executive Committee or to another source inside or outside the Hospital for additional research or information; or

(3) reject or modify the recommendation. If the Board determines to reject the favorable recommendation, it should first discuss the matter with the Chairperson of the Medical Executive Committee. If the Board's determination remains unfavorable to the applicant, the CEO shall promptly notify the applicant by special notice that he or she is entitled to request a hearing.

Section 6. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within one hundred twenty (120) days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

Part E. Clinical Privileges:

Section 1. General:

(a) Medical Staff appointment or reappointment shall not automatically confer any clinical privileges or right to practice at the Hospital. Each staff appointee shall be entitled to exercise only those clinical privileges specifically granted by the Board.

(b) The grant of clinical privileges includes responsibility for emergency service call and other rotational obligations established to fulfill the Hospital's responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards. However, emergency call responsibility is neither a right nor a privilege, but an obligation to serve when assigned emergency call coverage.

(c) Clinical privileges shall be voluntarily relinquished only in the manner that provides for the orderly transfer of applicable obligations.

(d) In order for a request for privileges to be processed, the applicant must satisfy any applicable threshold eligibility criteria.

(e) The clinical privileges recommended to the Board shall be based upon consideration of the following:

(1) the applicant's education, relevant training, successful completion of an approved training program, experience, demonstrated current competence (including medical/clinical knowledge, technical and clinical skills), clinical judgment, references, utilization patterns, ability to perform the privileges requested competently and safely, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to the same;

(2) information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;

(3) appropriateness of utilization patterns;

(4) ability to perform the privileges requested competently and safely;

(5) availability of qualified physicians or other appropriate appointees to provide medical coverage for the applicant in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for the clinical privileges requested;

(7) the Hospital's available resources and personnel;

(8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(9) any information concerning professional review actions, voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

(10) practitioner-specific data as compared to aggregate data, when available;

(11) morbidity and mortality data, when available;

(12) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions; and

(13) other relevant information, including a written report and findings by the chairperson of each of the clinical department in which privileges are sought.

(f) The applicant shall have the burden of establishing qualifications for and current competence to exercise the clinical privileges requested.

(g) The reports of the clinical department chairperson of the clinical department in which privileges are sought shall be forwarded to the Credentials Committee and processed as a part of the initial application for staff appointment.

(h) During the term of appointment, an appointee may request increased privileges. The request shall be in writing and shall state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria. If the appointee is eligible and the request for privileges contains information deemed complete, it shall be processed in the same manner as an application for initial clinical privileges.

<u>Section 2. Clinical Privileges for Dentists</u>:

(a) The scope and extent of surgical procedures that a dentist may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.

(b) Surgical procedures performed by dentists shall be under the overall supervision of the chairperson of the Surgery Department and monitored by the Chairperson of the Dentistry Section.

(c) Oral surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee.

(d) The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. Dentists may write orders within the scope of their license and consistent with Hospital and Medical Staff Bylaws and Rules and Regulations.

<u>Section 3. Clinical Privileges for Podiatrists</u>:

(a) The scope and extent of surgical procedures that a podiatrist may perform in this Hospital shall be delineated and recommended in the same manner as other clinical privileges and in accordance with the provisions of these Bylaws and any applicable

policies governing such individuals as may be adopted by the Board from time to time.

(d) Surgical procedures performed by podiatrists shall be under the overall supervision of the chairperson of the Surgery Department.

(c) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination as well as all appropriate elements of the patient's record. Podiatrists who admit patients without underlying health problems, defined as ASA class I or II, may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee. Podiatrists may write orders which are within the scope of their license, consistent with the Hospital and Medical Staff bylaws and rules and regulations.

Section 4. Residents:

(a) Residents in training at the Hospital shall **not** hold appointments to the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Medical Executive Committee or its designee and the Board or its designee. The program director, clinical faculty and/or a designated Medical Staff appointee shall be responsible for the direction and supervision of the on-site, day-to-day patient care activities of each resident.

(b) The clinical functions granted to residents shall be limited to the specialty and duration of the resident's training program and shall be subject to supervision at all times as specified by residency manuals and policies and the ACGME, AOA, American College of Osteopathic Family Physicians, and Council on Podiatric Medical Education guidelines.

(c) The program director shall be responsible for verifying and evaluating the qualifications of each resident.

(d) Medical Staff appointees who participate in overseeing residents shall be provided with a written description of the role, responsibilities and patient care activities of the residents. These descriptions shall include identification of the mechanisms by which the supervising physician and program director make decisions regarding each resident's progressive involvement and independence in specific patient care activities.

(e) The residency program director shall report to the Medical Executive Committee at least yearly concerning:

(1) the educational programs being offered at the Hospital;

(2) written descriptions of the role, responsibilities and patient care activities of the residents;

(3) the safety and quality of patient care provided by the program participants;

(4) the related educational and supervisory needs of the residents; and

(5) the delineation of who may write patient care orders, the circumstances under which they may do so and what entries, if any, must be countersigned.

Section 5. Clinical Privileges for New Procedures:

(a) Requests for clinical privileges to perform a procedure or service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure), will not be processed until a determination has been made that the technique/procedure/service will be offered by the Hospital and criteria for the clinical privilege(s) have been adopted.

(b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the department chairperson and the Credentials Committee addressing the following:

(1) minimum education, training, and experience necessary to perform the new procedure safely and competently;

(2) clinical indications for when the new procedure is appropriate;

(3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;

(4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;

(5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and

(6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The department chairperson and the Credentials Committee will review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered at the Hospital.

(c) If the preliminary recommendation is favorable, the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding

(1) the minimum education, training, and experience necessary to perform the procedure or service;

(2) the clinical indications for when the procedure or service is appropriate;

(3) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted; and

(4) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities.

(d) The Credentials Committee shall forward its recommendation to the Medical Executive Committee, which shall review the matter and forward its recommendation to the Board (or the Executive Committee of the Board) for final action.

Section 6. Clinical Privileges that Cross Specialty Lines:

(a) Requests for clinical privileges that previously have been exercised only by members in another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the member's eligibility to request the clinical privilege(s) in question.

(b) As an initial step in the process, the individual seeking the privilege will submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the clinical privilege at other similar hospitals, and the experiences of those other hospitals.

(c) The Credentials Committee will verify that the privilege(s) is not subject to an exclusive agreement.

(d) The Credentials Committee will then conduct additional research and consult with experts, as necessary, including those on the Hospital's Medical Staff (e.g. appropriate clinical department chairpersons or other individuals on the Medical Staff with special interest and/or expertise in the privileges in question) or those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).

(e) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee shall then develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the clinical privileges in question;

(2) the clinical indications for when the procedure is appropriate;

(3) the manner of addressing the most common complications that arise, which may be outside the scope of the clinical privileges that have been granted to the requesting individual;

(4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;

(5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing focused professional practice evaluation (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and

(6) the impact, if any, on emergency call responsibilities.

a. The Credentials Committee shall forward its recommendations to the Medical Executive Committee, which shall review the matter and forward its recommendation to the Board (or the Executive Committee of the Board) for final action.

Section 7. Contracted Services:

(a) It is understood that the Hospital may enter into contracts with physicians and/or groups of physicians for the performance of clinical and/or administrative services at the Hospital. All individuals providing services pursuant to those contracts must obtain and maintain Medical Staff appointment and clinical privileges at the Hospital, in accordance with the terms of these Bylaws.

(b) As a practical matter, if an exclusive contract confers the exclusive right to perform certain services at the Hospital, other individuals cannot exercise clinical privileges to perform those services while the contract is in effect.

(c) Therefore, if an exclusive contract would effectively prevent an existing Medical Staff member from exercising clinical privileges that had previously been granted, the Board will notify the member and invite the member to meet with the Board or its designee to discuss the matter and present any information that the member believes is relevant to the Board's decision to enter into the exclusive contract.

Individuals are not entitled to any other procedural rights with respect to the Board's decision to enter into an exclusive contract or the effect of any such contract on the member's clinical privileges. The inability of a physician to exercise clinical privileges because of an exclusive contract is not a matter that requires a report to the Wisconsin licensure board or to the National Practitioner Data Bank.

(d) In the event of any conflict between the Medical Staff Bylaws and the terms of any contract, the conflict shall be handled in accordance with the Conflict Management Process further described in these Bylaws at Article XI - Part C.

Section 8. Supervision of Allied Health Professionals:

Any physician who employs an allied health professional to perform clinical activities/functions in the Hospital shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of that allied health professional. All physicians employing such individuals are advised to consult the Allied Health Professionals section of these Bylaws for details concerning the use of allied health professionals in the Hospital.

Part F. Voluntary Relinquishment of Privileges:

Section 1. Request to Relinquish Clinical Privileges:

(a) A Medical Staff appointee who desires to voluntarily relinquish any one (1) or more of the clinical privileges granted at any time during the appointment period may submit a written request to the President of the Medical Staff specifying the clinical privilege(s) to be relinquished. The relinquishment of privileges shall not be effective until acknowledged in writing by the Board.

(b) The procedure set forth in this Part shall not apply to situations where the appointee has been deemed by the Hospital to have automatically relinquished privileges pursuant to the Medical Staff Bylaws, Rules and Regulations or the Hospital bylaws or policies.

(c) Likewise, voluntary relinquishment of clinical privileges while under an investigation or in return for not conducting an investigation shall be considered a "surrender" of such privileges, and shall be so reported when required.

Section 2. Procedure for Relinquishment of Clinical Privileges:

(a) Upon the receipt of a request to relinquish one (1) or more clinical privileges, the President of the Medical Staff and/or the Medical Executive Committee shall review the request, consult with the applicable clinical department chairperson, and forward a recommendation to the Board for final action. The President of the Medical Staff and/or the Medical Executive Committee may request a meeting with the appointee involved if the decrease of the clinical privileges would create a

deficiency in available Hospital services. A report of such meeting shall be submitted to the Board with the recommendation of the President of the Medical Staff and/or the Medical Executive Committee.

(b) The Board shall act on the request and its decision shall be reported in writing by the CEO to the appointee, the Medical Executive Committee, the Credentials Committee and the applicable clinical department chairperson. The decision of the Board shall specify a specific date on which relinquishment of clinical privilege(s) shall become effective.

(c) Failure to request relinquishment of any clinical privileges pursuant to this Part or to adhere to the effective date specified by the Board for the relinquishment of the clinical privileges in question shall constitute grounds for professional review action pursuant to these Bylaws.

Part G. Procedure for Temporary Clinical Privileges:

Section 1. Temporary Clinical Privileges for Applicants:

(a) Temporary clinical privileges may be granted by the CEO, upon recommendation of the President of the Medical Staff, when there is an important patient care, treatment or service need. Specifically, temporary privileges may be granted for the following reasons:

(1) the care of a specific patient;

(2) when necessary to prevent a lack or lapse of services in a needed specialty area; or

(3) when a physician is participating as a student in a special training program offered at the Hospital under the supervision of a member of the Medical Staff.

Prior to granting temporary privileges in these situations, the CEO shall verify current licensure and current competence.

(b) Temporary privileges may be granted only after the CEO has consulted with the applicable clinical department chairperson and the Chairperson of the Credentials Committee.

(c) Prior to temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures and protocols of the Medical Staff and the Hospital.

(d) Temporary privileges shall be granted for a specific period of time as warranted by the situation. In no situation should the initial grant of temporary privileges be for a period exceeding ninety (90) days.

(e) Temporary privileges shall expire at the end of the time period for which they are granted.

(f) In exercising such privileges, the applicant shall act under the supervision of the clinical department chairperson of the department in which the applicant has requested primary privileges.

Section 2. Locum Tenens:

(a) The CEO, after consulting with the President of the Medical Staff, the clinical department chairperson, and the Credentials Committee chairperson, may grant temporary admitting and clinical privileges to an individual serving as a locum tenens for an appointee of the Medical Staff to attend patients of that appointee, or may grant locum tenens privileges at the request of the Hospital to provide coverage in a specialty area in which there is no coverage or a shortage of individuals to provide coverage.

(b) Prior to granting locum tenens privileges, the CEO or designee shall verify the individual's licensure, DEA and state controlled substance certification, character, ethical standing, ability to perform the privileges requested competently and safely, and professional liability insurance coverage; query the National Practitioner Data Bank; and obtain the individual's signed acknowledgment to be bound by all of the Bylaws, policies, Rules and Regulations of the Medical Staff and the Hospital. Verification of board certification with participation in a Program for Maintenance of Certification (MOC) or completion of 30 hours of continuing medical education within the previous two years is also required prior to granting locum tenens privileges.

(c) Locum tenens coverage shall be limited to a time frame not to exceed one hundred twenty (120) days annually, unless such time limitation is waived by the Board or its designee in those situations where there is no medical coverage and the desired specialty or a physician shortage exists in a clinical specialty area.

(d) Locum tenens designation is a courtesy offered by the Hospital for Medical Staff appointees who are unavailable, or when necessary to the Hospital while it implements the Board's Medical Staff strategic planning objectives.

Section 3. Special Requirements:

Special requirements of supervision and reporting may be imposed by the applicable clinical department chairperson on any individual granted temporary clinical privileges. Temporary

privileges shall be immediately terminated by the CEO or a designee upon notice of any failure by the individual to comply with such special conditions.

Section 4. Termination of Temporary Clinical Privileges:

(a) The CEO may, at any time after consulting with the President of the Medical Staff, the Credentials Committee chairperson or the clinical department chairperson responsible for the individual's supervision, terminate temporary admitting privileges. The termination shall then be effective when the individual's patients are discharged from the Hospital, or effective immediately if it is determined that the care or safety of patients would be endangered by continued treatment by the individual granted temporary privileges, or if the individual fails to comply with any condition.

(b) The appropriate clinical department chairperson or the President of the Medical Staff shall assign to a Medical Staff appointee responsibility for the care of patients until they are discharged from the Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.

(c) The granting of any temporary admitting and clinical privileges is a courtesy on the part of the Hospital. Neither the granting, denial or termination of such privileges shall entitle the individual to request a hearing.

(d) Temporary privileges shall be automatically terminated at such time as the Credentials Committee recommends not to appoint the applicant to the staff. Similarly, temporary clinical privileges shall be modified to conform to the recommendation of the Credentials Committee (and/or the Medical Executive Committee) that the applicant be granted clinical privileges different from the temporary privileges.

Part H. Emergency Clinical Privileges:

1. For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.

2. In an emergency situation, a Member may administer treatment to the extent permitted by that individual's license regardless of that individual's clinical department status or specific grant of clinical privileges.

3. When the emergency situation no longer exists, the patient shall be assigned by the appropriate clinical department chairperson or the President of the Medical Staff to an appointee with appropriate clinical privileges. The wishes of the patient shall be considered in the selection of a substitute physician.

Part I. Telemedicine Privileges:

1. Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services. Telemedicine services can be provided simultaneously (i.e. teleICU) or non-simultaneously (i.e. Teleradiology). The Board shall determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate clinical department chairperson, the Credentials Committee, and the Medical Executive Committee.

2. Individuals applying for telemedicine privileges shall meet the qualifications for Medical Staff appointment outlined in these Bylaws, except for those requirements relating to geographic residency, coverage arrangements, and emergency call responsibilities.

3. Individuals who hold privileges in other classifications of the Medical Staff are not required to apply for telemedicine privileges in order to use electronic communication or other communication technology to provide or support clinical care at a distance.

4. Qualified applicants may be granted telemedicine privileges but shall not be appointed to the Medical Staff. Telemedicine privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

5. Applications for telemedicine privileges shall be processed in accordance with the provisions of these Bylaws in the same manner as for any other applicant, except that the Hospital may utilize the credentialing information provided by a telemedicine entity (as that term is defined by CMS) if the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or the applicant's primary hospital/group, provided that the hospital/group is accredited by the Joint Commission. There must be a written contract between the primary hospital/group and the Hospital, the applicant must be privileged at the primary hospital/group for the privileges requested, the primary hospital/group must provide evidence of an internal review of the practitioner, and the primary hospital/group must provide information about adverse events that resulted from the telemedicine services and any complaints they received about the practitioner.

6. Telemedicine privileges, if granted, will be for a period of not more than two (2) years. Individuals seeking to renew telemedicine privileges shall be required to complete an application and, upon request, provide the Hospital with evidence of current clinical competence. This information may include, but is not limited to, a quality profile from the applicant's primary practice affiliation and evaluation form(s) from qualified supervisor(s). If all requested information is not received by dates established by the Hospital, the individual's telemedicine privileges shall expire at the end of the current term. Once all information is received and verified, an application to renew telemedicine privileges shall be processed as set forth above.

7. Individuals granted telemedicine privileges shall be subject to the Hospital's performance improvement, ongoing and focused professional practice evaluations and other peer review activities. The results of the peer review activities, including any adverse events and

complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the Hospital or entity providing telemedicine services.

Part J. Core Privileges:

Section 1. Application Process Requirements:

Individuals requesting clinical privileges at the Hospital are required to apply for core privileges in their specialties as may be defined by each clinical department. The scope of core privileges for each clinical department shall be recommended by the clinical department chairperson and must be approved by the Credentials Committee, Medical Executive Committee, and the Board. Core privileges (and the eligibility criteria related to them) may be revised if recommended by the clinical department chairperson and approved by the Credentials Committee, Medical Executive Committee, and the Board.

Section 2. Rules Governing Exercise of Core Privileges:

Individuals who have been granted core privileges shall be required to do the following:

(a) provide emergency call coverage for patients requiring emergency care within the scope of their core privileges; and

(b) provide consultations for patients requiring consults within the scope of their core privileges.

Section 3. Exemption from Core Privileges:

(a) Any individual who wishes to be exempt from a particular privilege(s) within the core for a specialty must apply for an exemption in writing, documenting the good cause basis for the request.

(b) After considering the recommendations from the relevant clinical department chairperson and the Credentials Committee, the Medical Executive Committee shall make a recommendation in support of or against such exemption. The following factors may be considered by the Medical Staff leadership in their review of the request:

(1) the Hospital's mission and its obligation to serve the health care needs of the community by providing timely, quality health care on a local basis;

(2) fairness to the individual requesting the exemption, including past service and the other demands placed upon the individual;

(3) fairness to the other Medical Staff members who serve on the call roster in that specialty, including the effect that the removal would have upon them;

(4) any gaps in call coverage that might/would result from a Medical Staff member's removal from the call roster for the specific privilege and the feasibility and safety of transferring patients to other facilities in that situation;

(5) the expectations of other members of the Medical Staff who are in different specialties but who routinely rely on the specialty in question in the care of the patients who present to the Emergency Department;

(6) the perceived inequities in exemptions being available to some; and

(7) how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.

(c) If the Medical Executive Committee recommends against granting an exemption, the individual shall be entitled to appear before the Medical Executive Committee before the Medical Executive Committee makes a final recommendation to the Board.

(d) If the Medical Executive Committee recommends in favor of granting the exemption, the recommendation shall be forwarded to the Board for its review and action.

(e) The Board shall make a final decision on the exemption request based upon consideration of the factors set forth in (b) of this Section. The Board's decision shall be reported in writing by the Chief Executive Officer to the requesting member, the Medical Executive Committee, and the applicable clinical department chairperson, and shall specify the effective date of the exemption.

(f) No individual is entitled to an exemption or to a hearing if the Board determines not to grant an exemption. A denial of a request for exemption does not entitle an individual to the procedural rights contained in Article IX of these Bylaws.

Section 4. Special Privileges Beyond the Core:

Individuals who have requested and been granted special privileges in addition to the core privileges for their specialty shall be required to provide such services on an emergency and consultative basis, as may be requested.

Part K. Mass Disasters:

1. Disaster privileges may be granted when the emergency management plan has been activated and the Hospital is unable to provide all the care required by individuals seeking treatment at the Hospital. Under such circumstances, the CEO or the President of the

Medical Staff, or a designee may grant privileges or permission to treat patients to volunteer physicians, nurses and other health care professionals upon satisfactory evidence of a valid government-issued photo identification issued by a state or federal agency (e.g. driver's license or passport) and at least one of the following:

(a) a current picture hospital ID card;

(b) a current license to practice and a valid picture ID issued by a state, federal or regulatory agency;

(c) identification indicating that the individual is a member of a Disaster Medical Assistance Team ("DMAT"), the Medical Reserve Corps ("MRC"), the Emergency System for Advance Registration of Volunteer Health Professionals ("ESAR-VHP"), or other recognized state or federal response organizations or groups;

(d) identification indicating that the individual has been granted authority to render patient care in disaster circumstances, such as authority having been granted by a federal, state or municipal entity; and/or

(e) presentation by or verification from a current hospital or Medical Staff appointee with personal knowledge regarding a practitioner's identity.

2. The CEO and/or President of the Medical Staff is not required to grant disaster privileges to any individual and is expected to exercise discretion and make such decisions on a case-by-case basis.

3. Individuals granted disaster privileges shall function within the scope of their license and/or as directed by the disaster coordinator.

4. Volunteer practitioners granted disaster privileges shall be provided with a Hospital-approved identification badge indicating their provider level and specialty.

5. The verification process of the credentials and privileges of individuals who receive disaster privileges shall begin as soon as the immediate disaster situation is under control and must be completed within 72 hours from the time the volunteer begins to provide services at the Hospital. The process established under the Bylaws regarding Medical Staff appointment, reappointment and clinical privileges for the granting of temporary privileges shall be implemented.

6. The professional practice performance of volunteer practitioners granted disaster privileges will be overseen by current medical staff appointees by a combination of direct observation, mentoring and concurrent clinical record review, or other appropriate mechanism developed by the Medical Staff and the Hospital.

7. A decision will be made, based on information obtained regarding the professional practice of the volunteer, related to the continuation of the disaster privileges within 72 hours of

initial granting of disaster privileges. When the disaster situation no longer exists, the disaster privileges shall expire.

8. In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

Part L. Leave of Absence:

1. An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the President of the Medical Staff. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.

2. Members of the Medical Staff must report to the Medical Executive Committee any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the Medical Executive Committee, in consultation with the Chief Executive Officer or Chief Physician Executive, may trigger an automatic leave of absence.

3. The Medical Executive Committee shall determine whether a request for a leave of absence shall be granted, subject to the approval of the Board. In determining whether to grant a request, the Medical Executive Committee shall consult with the Chief Executive Officer or Chief Physician Executive and the relevant department chairperson. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

4. A Medical Staff member may request and be granted a leave of absence to fulfill military service obligations. Medical staff members who are on active military duty for more than one year will be afforded an automatic extension of their leave until their active duty is completed. Reinstatement of membership status and/or clinical privileges may be subject to certain monitoring as determined by the Department Chairperson or Credentials Committee, based on an evaluation of the nature of activities during the leave.

5. During the leave of absence, the individual shall not exercise any clinical privileges. In addition, the individual shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

6. Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital.

Requests for reinstatement shall then be reviewed by the relevant department chairperson and the Chairperson of the Credentials Committee. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Medical Executive Committee, and Board for review and recommendation. However, if a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.

7. If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested. At the request of the Medical Executive Committee or Board, the individual may be required to submit to a medical examination by a practitioner acceptable to the Medical Staff leadership and Hospital.

8. Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Chief Executive Officer or Chief Physician Executive. As a general rule, extensions will be granted to allow a member to complete mandatory military service. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

9. If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges shall lapse at the end of the appointment period, and the individual shall be required to apply for a new appointment.

10. Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

ARTICLE VII

ACTIONS AFFECTING MEDICAL STAFF APPOINTEES

Part A. Procedure for Reappointment:

All terms, conditions and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

Section 1. Application:

(a) Each current appointee who is eligible to be reappointed to the Medical Staff shall be responsible for completing a reappointment application form. An application for

reappointment shall be furnished to members at least three months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office or designated Central Verification Office within 30 days.

(b) Failure to submit an application for reappointment at least two months prior to the expiration of the Member's current term will result in automatic expiration of the individual's appointment and clinical privileges at the end of the current term of appointment, unless the application can still be processed in the normal course, without extraordinary effort on the part of the Medical Staff Office and/or the Medical Staff leaders. The individual may not practice until the application is completely processed.

(c) Reappointment, if granted by the Board, shall be for a period of not more than two (2) years, with reappointments staggered in a manner established by the Medical Staff Office.

(d) If an application for reappointment is filed timely and the Board has not acted on it prior to the expiration of the individual's current appointment term, the CEO shall have the authority to grant the individual temporary appointment and clinical privileges, if applicable, until such time as the Board (or the Executive Committee of the Board) can act on the application, if an important patient care need exists. Temporary privileges shall be granted only in accordance with Article VI, Part G.

(e) In the event the applicant for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two (2) years may be granted pending the completion of that process.

(f) The application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all eligibility criteria for reappointment consideration and for the clinical privileges requested.

(g) The Medical Staff Office shall oversee the process of gathering and verifying relevant information and shall also be responsible for confirming that all relevant information has been received.

(h) The Medical Staff Office shall forward the application to the clinical department chairperson and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.

Section 2. Factors to be Considered:

(a) In considering an individual's application for reappointment, the factors listed in Article VI, Part E, Section 1 of these Bylaws shall be considered. Peer references

will not be required for reappointment. Additionally, each recommendation concerning reappointment shall be based upon an appointee's:

(1) patient contacts at the Hospital during the previous appointment term;

(2) ethical behavior, and current clinical competence, judgment and technical skill in the treatment of patients;

(3) participation in staff responsibilities;

(4) compliance with the Bylaws, policies and Rules and Regulations of the Medical Staff and the Hospital;

(5) behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of this Hospital, and the ability to work with others;

(6) use of the Hospital's facilities for patients, taking into consideration the results of the Hospital's performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified), practitioner-specific information compared to aggregate data, including, but not limited to, conformity to clinical protocols or pathways;

(7) current ability to perform the clinical privileges requested competently and safely;

(8) capacity to satisfactorily treat patients as indicated by the results of the Hospital's quality assessment/performance improvement activities or other reasonable indicators of continuing qualifications, including reports from the National Practitioner Data Bank and any current malpractice actions;

(9) satisfactory completion during the previous appointment term of applicable continuing education requirements as may be imposed by law, regulation, applicable accreditation agencies, and the Hospital;

(10) current professional liability insurance status and pending malpractice claims, lawsuits, judgments and settlements;

(11) current licensures, including pending challenges to any license or registration;

(12) voluntary or involuntary termination of Medical Staff appointment, limitation, reduction, or loss of clinical privileges at another hospital;

(13) any focused professional practice evaluations;

(14) verified complaints received from patients and/or staff; and

(15) other reasonable indicators of continuing qualifications.

(b) To be eligible to apply for renewal of clinical privileges, an individual must have performed sufficient procedures, treatments, or therapies in the previous appointment term to enable the clinical department chairperson and the Credentials Committee to assess the applicant's current clinical competence for the privileges requested. Any individual seeking reappointment who has minimal activity at this Hospital must submit a copy of his or her confidential QA profile from the individual's primary hospital, if applicable, and/or such other information as may be requested, before the individual's reappointment application shall be considered complete and processed further.

Section 3. Clinical Department Chairperson Procedure:

(a) When an application is deemed complete, the Medical Staff Office shall make available to the clinical department chairperson the completed applications of all appointees who have clinical privileges in that department, including a description of the clinical privileges each holds.

(b) After receipt of the applications, the clinical department chairperson or a designee shall provide the Credentials Committee with a written report concerning each individual seeking reappointment. The clinical department chairperson shall include in each written report, when applicable, the reasons for any changes recommended in staff category, in clinical privileges, or for non-reappointment. The clinical department chairperson or designee concerned shall be available to the Credentials Committee to answer any questions that may be raised concerning the reappointment application and the clinical department chairperson's report.

Section 4. Credentials Committee Procedure:

(a) The Credentials Committee shall review all pertinent information available, including the clinical department chairperson's or designee's report, all information provided from other committees of the Medical Staff and from Hospital management, and make its recommendations for staff reappointment, for change in staff category, and for the granting of clinical privileges.

(b) The Credentials Committee may require the individual to meet with the committee to discuss any aspect of the individual's reappointment application, qualifications, or clinical privileges requested.

(c) The Credentials Committee may use the expertise of the clinical department chairperson, or any member of the clinical department, or an outside consultant, if additional information is required regarding the individual's qualifications for reappointment.

(d) After determining that the appointee is qualified for reappointment and privileges, the Credentials Committee may require an individual currently seeking reappointment to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Credentials Committee either as part of the reapplication process or at any time during the appointment period to aid it in determining whether clinical privileges should be granted or continued. The results of such examination shall be available for the Credentials Committee's consideration. Failure of an individual seeking reappointment to undergo such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the reappointment application, and all processing of the application shall cease.

(e) If, after considering the report of the clinical department chairperson or designee concerned, the Credentials Committee's recommendation is favorable, it shall recommend reappointment and the specific clinical privileges to be granted, which may be qualified by any conditions deemed appropriate by the committee.

(f) The Credentials Committee shall forward written findings and recommendations to the Medical Executive Committee in time for the Medical Executive Committee to consider the individual's reappointments at its regularly scheduled meeting before the expiration of the applicant's appointment period. The completed application and all supporting documentation shall accompany the Credentials Committee's findings and recommendation. Where non-reappointment, non-promotion, or a change in clinical privileges is recommended, the reason shall be stated. The Chairperson of the Credentials Committee shall be available to the Medical Executive Committee (or to the Board or the Executive Committee of the Board) to answer any questions that may be raised with respect to the recommendation.

Section 5. Medical Executive Committee Procedure:

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:

(1) adopt the findings and recommendation of the Credentials Committee;

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or

(3) state in its report clear and convincing reasons for its disagreement with the Credentials Committee's recommendation. Thereafter, the Medical

Executive Committee's recommendation shall be forwarded, together with the Credentials Committee's findings and recommendation, through the CEO to the Board (or the Executive Committee of the Board).

(b) If the recommendation of the Medical Executive Committee is for reappointment and clinical privileges, it shall forward its recommendation, together with all supporting documentation, through the CEO to the Board (or the Executive Committee of the Board).

(c) If the recommendation of the Medical Executive Committee would entitle the affected individual to request a hearing, it shall be forwarded to the CEO, who shall promptly notify the affected individual in writing, certified mail, return receipt requested. The CEO shall then hold the recommendation until after the individual has exercised or has waived the right to a hearing and appeal, after which time the CEO shall forward the recommendation of the Medical Executive Committee, together with all supporting documentation, to the Board (or the Executive Committee of the Board) for further action. The Chairperson of the Medical Executive Committee shall be available to the Board (or the Executive Committee of the Board) to answer any questions that may be raised with respect to the recommendation.

(d) In the event the Board determines to consider modification of the recommendation of the Medical Executive Committee that would entitle the individual to request a hearing, the CEO shall notify the affected individual. No final action shall occur until the individual has exercised or has waived the right to a hearing and appeal.

Section 6. Meeting with Affected Individual:

If, during the processing of an individual's reappointment request, it becomes apparent to the Credentials Committee or its Chairperson that the committee is considering a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges, or reduce clinical privileges, the Chairperson of the Credentials Committee may notify the individual of the general tenor of the possible recommendation and ask if the individual would like to meet with the committee prior to any final recommendation. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be offered the opportunity to discuss, explain or refute it. The meeting is not a hearing, and none of the procedural rules for a hearing shall apply. The committee shall indicate as part of its report whether such a meeting occurred, and shall include a summary of the meeting within its minutes.

Section 7. Conditional Reappointments:

(a) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Unless

the conditions involve the matters set forth in Article IX - Part A, Section 1 of these Bylaws, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article IX of these Bylaws.

(b) In the event the application for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

(c) In addition, reappointments may be recommended for periods of less than two (2) years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article IX.

<u>Section 8. Time Periods for Processing</u>:

Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

<u>Part B. Procedures for Requesting Additional Clinical Privileges</u>:

<u>Section 1. Request for Additional Clinical Privileges</u>:

Whenever, during the term of appointment, additional clinical privileges are desired, the appointee requesting increased privileges shall apply in writing on a form approved by the Board and available in the Medical Staff Office. The request shall state the specific additional clinical privileges desired and sufficient information to establish eligibility, as specified in applicable criteria. If the individual is eligible and the application complete, it shall be transmitted by the Medical Staff Office to the appropriate clinical department chairperson. Thereafter, it shall be processed in the same manner as an application for initial clinical privileges.

<u>Section 2. Factors to be Considered</u>:

(a) Recommendations for additional clinical privileges shall be based upon:

(1) relevant recent training;

(2) observation of patient care provided;

(3) review of the records of patients treated in this or other hospitals;

(4) results of the Hospital's quality assessment/performance improvement activities; and

(5) other reasonable indicators of the individual's qualifications for the privileges in question.

(b) The recommendation for additional privileges may include requirements for supervision or other conditions for such periods of time as are thought necessary.

Part C. Issues Involving Medical Staff Members:

Section 1. Options Available to Medical Staff Leaders and Hospital Administration:

(a) Medical Staff Leaders and Hospital Administration are empowered to use various options to address and resolve issues that may be raised about members of the Medical Staff. The various options available to Medical Staff Leaders and Hospital Administration and the mechanisms they may use when issues pertaining to competence, health or behavior are raised are outlined below and include, but are not limited to, the following:

(1) collegial intervention and progressive steps;

(2) ongoing and focused professional practice evaluations;

(3) mandatory meeting;

(4) fitness for practice evaluation (including blood and/or urine test);

(5) automatic relinquishment of appointment and clinical privileges;

(6) leaves of absence;

(7) precautionary suspension; and

(8) formal investigation.

(b) In addition to these options, Medical staff Leaders and Hospital Administration also have the discretion to determine whether a matter should be handled in accordance with another policy (e.g. HSHS code of conduct policy, Practitioner Health Policy, Peer Review Policy) or should be referred to the Medical Executive Committee for further action.

Section 2. Documentation;

(a) Except as otherwise expressly provided, Medical Staff Leaders and Hospital Administration may use their discretion to decide whether to document any meeting with an individual that may take place pursuant to the processes and procedures outlined in this Article.

(b) Any documentation that is prepared will be shared with the individual. The individual will have an opportunity to review the documentation and respond to it. The initial documentation, along with any response, will be maintained in the individual's credentials file.

Section 3. No Recordings of Meetings;

It is the policy of the Hospital to maintain the confidentiality of all Medical Staff meetings, including, but not limited to, discussions relating to credentialing, quality assessment, performance improvement, and peer review activities. The discussions that take place at such meetings are private conversations that occur in a private place. In addition to existing bylaws and policies governing confidentiality, individuals in attendance at such meetings are prohibited from making audio or video recordings at such meetings.

Section 4. No Right to Counsel;

(a) The processes and procedures outlined in this Article are designed to be carried out in an informal manner. Therefore, lawyers will not be present for any meeting that takes place pursuant to this Article. By agreement of the President of the Medical Staff and Chief Executive Officer, an exception may be made to this general rule.

(b) If the individual refuses to meet without his or her lawyer present, the meeting will be canceled and it will be reported to the Medical Executive Committee that the individual failed to attend the meeting.

Section 5. No Right to Presence of Others:

Peer review activities are confidential and privileged to the fullest extent permitted by law. Accordingly, the individual may not be accompanied by friends, relatives or colleagues when attending a meeting that takes place pursuant to this Article, unless agreed upon by the President of the Medical Staff.

Part D. Precautionary Suspension of Clinical Privileges:

Section 1. Grounds for Precautionary Suspension:

(a) The President of the Medical Staff, the clinical department chairperson, Chairperson of the Credentials Committee, CEO, CPE, or Chairperson of the Board shall each have the authority to suspend all or any portion of an individual's clinical privileges whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual or to the orderly operation of the Hospital. The individual may be given an opportunity to refrain voluntarily from exercising privileges pending an investigation.

(b) A precautionary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of a specific event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Executive Committee that would entitle the individual to request a hearing.

(c) Precautionary suspension is an interim precautionary step in the professional review activity, but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.

(d) A precautionary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the CEO and the President of the Medical Staff, and shall remain in effect unless or until modified by the CEO or the Medical Executive Committee.

(e) When possible, prior to the imposition of a precautionary suspension or restriction, the person(s) considering the suspension or restriction will meet with the individual and review the concerns that support the suspension or restriction and afford the individual an opportunity to respond.

Section 2. Request for Hearing and Medical Executive Committee Action:

(a) Request for Hearing. Any individual who is the subject of a precautionary suspension or restriction may request a hearing with the Medical Executive Committee. Any such request must be made in writing within three days of the imposition of the suspension or restriction. The hearing must then be held within 15 days of the imposition of the suspension or restriction (unless the individual and the Medical Executive Committee agree upon a different time frame/schedule). Prior to the hearing, the individual shall be provided a brief written description of the reason(s) for the precautionary suspension or restriction, including the names and medical record numbers of the patient(s) involved (if any).

(b) Scope of Hearing. The scope of any such hearing shall be limited to the appropriateness of imposing, and the need to continue, the precautionary suspension or restriction under the circumstances. At the hearing, the individual will be given an opportunity to personally discuss the matter with the Medical Executive Committee, provide additional information and documentation, and present witnesses to support his or her position. The individual may also propose ways other than a precautionary suspension or restriction to protect patients and other individuals. Neither the suspended individual nor the Medical Executive Committee shall be accompanied by counsel at this hearing.

(c) Medical Executive Committee Action. Whether or not a hearing is requested by the individual, the Medical Executive Committee shall review the information and circumstances resulting in the precautionary suspension or restriction and determine whether the action should be affirmed, lifted, or modified. The decision

of the Medical Executive Committee should be made as soon as practical following the suspension or restriction, but not later than 10 days following the date of the hearing (if one is requested).

(1) Affirmed. The Medical Executive Committee may affirm the precautionary suspension or restriction pending completion of a formal investigation pursuant to Article VIII of these Bylaws. If, following the formal investigation, the Medical Executive Committee makes another recommendation that would entitle the practitioner to a hearing under Article IX of these Bylaws, the practitioner may request such a hearing and it will be conducted in accordance with the provisions of Article IX.

(2) Lifted or Modified. If the Medical Executive Committee determines that the precautionary suspension or restriction should be lifted or modified, this decision shall take effect immediately. The Medical Executive Committee shall then take whatever next steps are appropriate under the circumstances, which could include proceeding with a formal investigation pursuant to Article VIII of these Bylaws. The Board (or a committee of the Board) shall review the Medical Executive Committee's determination to lift or modify the suspension or restriction on an expedited basis. If the Board (or committee) disagrees with the determination of the Medical Executive Committee, representatives of the Board and the Medical Executive Committee shall meet to discuss the matter and determine appropriate next steps.

Section 3. Care of Suspended Individual's Patients:

(a) Immediately upon the imposition of a precautionary suspension, the appropriate clinical department chairperson or a designee or, if unavailable, the President of the Medical Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's patients still in the Hospital. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of the assigned appointee.

(b) All Medical Staff appointees have a duty to cooperate with the President of the Medical Staff, clinical department chairperson, Medical Executive Committee, and CEO in enforcing suspensions.

Part E. Automatic Relinquishment:

Section 1. Failure to Complete Medical Records:

(a) The elective and emergency admitting privileges of a Medical Staff appointee, except with respect to those patients already in the Hospital, shall be automatically relinquished for failure to complete medical records after notification of delinquency by the Medical Records Department, unless the appointee is without

fault in causing the delinquency. A medical record is considered to be delinquent fourteen (14) days after discharge. Written notice of such automatic relinquishment shall be forwarded to the affected individual by the Medical Staff Office with notification to the appropriate clinical department chairperson. Relinquishment shall continue until all the delinquent records are completed. Failure to complete the medical records that caused relinquishment of clinical privileges within sixty (60) days from the date of the first notification of relinquishment shall result in automatic resignation from the Medical Staff.

(b) For the purpose of enforcing this Section, extensions may be granted for justified reasons for delay in completing medical records which shall include, but not be limited to, the following:

(1) the staff member or other individual contributing to the medical record is ill, on vacation, or otherwise unavailable for a period of time;

(2) the staff member is waiting for the results of a late report and the medical record is otherwise complete except for the discharge summary and the final diagnosis; and/or

(3) the staff member has dictated reports, including but not limited to, discharge summaries, and is waiting for transcription to be complete.

Section 2. Action by Government Agency or Insurer and Failure to Satisfy Threshold Eligibility Criteria:

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below or failure to satisfy any of the threshold eligibility criteria set forth in these Bylaws must be promptly reported to the President of the Medical Staff.

(b) An individual's appointment and clinical privileges shall be automatically relinquished if any of the following occur:

(1) Licensure: Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's license. In the event the individual's license is only partially restricted, the clinical privileges that would be affected by the license restriction shall automatically be similarly restricted.

(2) Controlled Substance Authorization: Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's DEA or state controlled substance authorization. Whenever an individual's state or federal controlled substance certificate is subject to probation, the individual's right to prescribe such medications shall automatically become subject to the same terms of the probation.

(3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall below the minimum required by the Hospital or cease to be in effect, in whole or in part.

(4) Medicare and Medicaid Participation: Termination, exclusion or preclusion from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) Criminal Activity: Indictment, conviction, or a plea of guilty or no contest to any felony involving violence against another or a felony or misdemeanor involving (a) controlled substances; (b) illegal drugs; (c) Medicare, Medicaid, or insurance or health care fraud or abuse; (d) conversion, misappropriation of property or embezzlement; or bribery, evidence tampering, or perjury.

(6) Imprisonment: Imprisonment in any state or federal prison for any period of time as a result of a conviction or pleas of guilty or no contest pertaining to any felony.

(c) An individual's appointment and clinical privileges shall be automatically relinquished if the individual fails to satisfy any of the threshold eligibility criteria set forth in these Bylaws.

(d) Automatic relinquishment shall take effect immediately upon notice to the Hospital and continue until the matter is resolved, if applicable. If an individual engages in any patient contact at the Hospital after the occurrence of an event that results in automatic relinquishment, without notifying the Hospital of that event, then the relinquishment shall be deemed permanent.

Section 3. Failure to Satisfy Continuing Education Requirements:

(a) Failure to complete mandated continuing education requirements shall result in automatic relinquishment of Medical Staff appointment and clinical privileges. Such failures shall be documented and specifically considered by the Credentials and Medical Executive Committees when making recommendations for reappointment and by the Board when making its final decisions.

(b) Any appointee who is ineligible for reappointment for failure to satisfy continuing education requirements shall be entitled to meet with the Executive Committee of the Board before final action is taken. This meeting with the Executive Committee of the Board shall not be conducted under the rules for a hearing as provided in these Bylaws.

(c) If reappointment is refused by the Executive Committee of the Board, the individual shall be eligible to reapply and the application shall be processed as if it were an initial application.

Section 4. Failure to Provide Information:

Appointment and clinical privileges shall be deemed to be automatically relinquished upon the occurrence of the following:

(a) failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges, in response to a written request by the Credentials or Medical Executive Committees or the CEO, or any other individual or committee authorized to request such information;

(b) discovery of a misstatement, misrepresentation or omission on an application for initial appointment or reappointment, determined by the President of the Medical Staff and CEO to be material and without good cause after considering any written or oral explanation provided by the individual;

(c) failure to notify the President of the Medical Staff, CEO, or CPE of any change in any information provided on an application for initial appointment or reappointment, determined by the President of the Medical Staff and CEO or CPE to be material and without good cause after considering any written or oral explanation provided by the individual; or

(d) failure to undergo a blood, hair or urine test or a complete physical or mental examination if at least two Medical Staff leaders or one Medical Staff leader and the CEO or CPE are concerned about the appointee's ability to safely and competently care for patients.

Automatic relinquishment of privileges shall continue until the requested information is provided.

Section 5. Failure to Attend Special Conference:

(a) Whenever there is a concern regarding an individual's clinical practice or professional conduct, Medical Staff leaders may require the individual to attend a special conference.

(b) Special notice will be given at least three (3) days prior to the conference and shall inform the individual that attendance at the conference is mandatory.

(c) Failure of the individual to attend the conference shall be reported to the Medical Executive Committee. Unless excused by the Medical Executive Committee upon a showing of good cause, such failure shall result in the automatic relinquishment of all or such portion of the individual's clinical privileges as the Medical Executive

Committee may direct. Such relinquishment shall remain in effect until the individual attends the special conference.

Section 6. Failure to Comply with Request for Fitness for Practice Evaluation:

(a) Failure of an applicant to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will be considered a voluntary withdrawal of the application.

(b) Failure of a member to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will result in the automatic relinquishment of appointment and privileges.

Section 7. Reinstatement from Automatic Relinquishment and Automatic Resignation:

(a) If the matter leading to the automatic relinquishment of appointment and privileges has been resolved within 90 days of the relinquishment, the individual may request to be reinstated.

(b) A request for reinstatement from an automatic relinquishment following completion of all delinquent records will be processed in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required will result in automatic resignation from the Medical Staff.

(c) Requests for reinstatement from an automatic relinquishment following the expiration or lapse of a license, controlled substance authorization, or insurance coverage will be processed by the Medical Staff Office. If any questions or concerns are noted, the Medical Staff Office will refer the matter for further review in accordance with (d) below.

(d) All other requests for reinstatement from an automatic relinquishment will be reviewed by the relevant department chairperson, the chairperson of the Credentials Committee, the President of the Medical Staff, the Chief Physician Executive, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request

will be forwarded to the full Credentials Committee, Medical Executive Committee and Board for review and recommendation.

(e) Failure to resolve a matter leading to an automatic relinquishment within 90 days of the relinquishment, and to be reinstated as set forth above, will result in an automatic resignation from the Medical Staff.

Section 8. Hearings Regarding Automatic Relinquishments:

(a) Any individual who is the subject of an automatic relinquishment of appointment and/or clinical privileges may request a hearing with the Medical Executive Committee. Any such request must be made within three days of the notice of the automatic relinquishment provided to the individual. The hearing must then be held within 15 days of the date of the automatic relinquishment (unless the individual and the Medical Executive Committee agree upon a different time frame/schedule).

(b) The hearing shall be governed exclusively by this Article VII – Part F, Section 8. The provisions of Article IX of these Bylaws shall not apply to hearings related to automatic relinquishments of Medical Staff appointment and/or clinical privileges.

(c) The scope of the hearing shall be limited to demonstrating that the event that led to the automatic relinquishment did not occur or that there was an extraordinary and unique circumstance that justified the event. At the hearing, the individual will be given an opportunity to personally discuss the matter with the Medical Executive Committee, provide additional information and documentation, and present witnesses to support his or her position. Neither the individual nor the Medical Executive Committee shall be represented by counsel at this hearing. The decision of the Medical Executive Committee following the hearing shall be final, with no right of further appeal.

Part F. Collegial Efforts and Informal Proceedings:

Section 1. Ongoing and Focused Professional Practice Evaluations:

(a) Individuals who are initially granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation to confirm their competence.

(b) All individuals who provide patient care services at the Hospital will have their care evaluated on an ongoing basis. This ongoing professional practice evaluation process may include an analysis of data to provide feedback and to identify issues in an individual's professional performance, if any.

(c) When concerns are raised about an individual's practice through the ongoing practice evaluation process or through a specialty-specific trigger, a reported concern, or other triggers (i.e., clinical trend or specific case that requires further

review, patient complaint, corporate compliance issue, or sentinel event), a focused professional practice evaluation will be undertaken to evaluate the concern.

(d) All ongoing and focused professional practice evaluations shall be conducted in accordance with the Medical Staff's peer review procedures. Matters that cannot be appropriately resolved through collegial intervention or through the peer review process shall be referred to the Medical Executive Committee for its review in accordance with Article VIII.

Section 2. Collegial Intervention:

(a) These Bylaws encourage the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

(b) Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement, and peer review.

(c) Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of staff members and pursuing counseling, education, and related steps, such as the following:

(i) advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

(ii) proctoring, monitoring, consultation, and letters of guidance; and

(iii) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

(d) The relevant Medical Staff leader(s) will determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation of collegial efforts is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response will be maintained in that individual's file along with the original documentation.

(e) Collegial intervention efforts are encouraged, but are not mandatory, and will be within the discretion of the appropriate Medical Staff leaders and Hospital management. No hearing rights will be triggered by any efforts taken pursuant to this Section.

(f) The relevant Medical Staff leader(s), in conjunction with the Hospital CEO or CPE, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., code of conduct policy; practitioner health policy; peer review policy). Medical Staff leaders may also direct these matters to the Medical Executive Committee for further action.

Section 3. Routine Monitoring and Education:

The Clinical Department and/or Committee are responsible for carrying out delegated review and quality improvement functions. They may counsel, educate, issue letters of warning or censure, or institute retrospective for concurrent proctoring or monitoring in the course of carrying out their duties, without initiating formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. The Practitioner shall be given an opportunity to meet with the Clinical Department or Committee. Any such informal actions shall be documented in the Practitioner's file. Medical Executive Committee approval is not required for such actions; although, the actions shall be reported to the Medical Executive Committee. The actions shall not constitute a restriction of privileges, nor shall they be grounds for any hearing or appeal rights under Article IX.

Section 4. Voluntary Remediation:

(a) Voluntary remediation may be appropriate when a problem or potential problem, though cause for concern, may or may not constitute grounds for formal corrective action and is of such a nature that voluntary measures can be taken to resolve it. Nothing in this Article, however, limits or restricts in any way the taking of corrective action at any time when warranted, nor shall voluntary remediation be interpreted as a mandatory first step or pre-condition to taking corrective action.

(b) Voluntary remediation is an authorized peer review activity of the Hospital and its Medical Staff. It can, depending on circumstances, function through a variety of ways, including but not limited to, informal interviews between a practitioner with the President of the Medical Staff/designee and/or the Medical Executive Committee. It may involve the use of outside consultants, reviewers, medical practitioners, counselors, therapists, mediators, and monitors. Those participating in voluntary remediation shall be deemed agents of the Hospital. Voluntary remediation sessions shall not constitute a formal corrective action hearing. Voluntary remediation sessions, those participating in them, and the data presented

are considered to be peer review protected by the confidentiality and immunity provisions under these Bylaws, as well as by Federal and State law.

(c) Voluntary remediation may be requested by a Department Chairperson, President of the Medical Staff, Medical Executive Committee, Governing Board or Hospital CEO or CPE.

(d) Voluntary remediation, which may include but is not limited to, education, training, monitoring, psychiatric and/or medical evaluation, counseling, treatment, or therapy, may be continued, as warranted, with the goal, if reason exists, of having the practitioner voluntarily sign a remedial action plan that outlines what steps that practitioner needs to take to remedy the problem. The remedial action plan may also contain language providing for corrective action if the terms of the voluntary remedial action plan are violated.

(e) A copy of the remedial action plan shall be kept in the practitioner's credentialing file. It shall not be disclosed or released to any party without written authorization by the practitioner, unless disclosure is required by applicable law.

(f) Because voluntary remediation does not constitute a professional review activity as described by the Health Care Quality Improvement Act of 1986, it shall not be deemed a reportable event to the State Medical Board or to the National Practitioner's Data Bank.

Section 5. Fitness for Practice Evaluation:

(a) An individual may be requested to submit to an appropriate evaluation (such as blood and/or urine test), or a complete fitness for practice evaluation to determine his or her ability to safely practice.

(b) A request for an evaluation may be made of an applicant by the Credentials Committee or Practitioner Health Committee during the initial appointment process or of a member during an investigation. A request for an evaluation may also be made when at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Hospital Administration) are concerned with the individual's ability to safely and competently care for patients.

(c) The Medical Staff Leaders or committee that requests the evaluation will: (i) identify the health care professional(s) to perform the evaluation; (ii) inform the individual of the time period within which the evaluation must occur; and (iii) provide the individual will all appropriate releases and/or authorizations to allow

the Medical Staff Leaders, or relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional(s) to discuss and report the results to the Medical Staff Leaders or relevant committee.

(d) Failure to obtain the requested evaluation may result in an application being withdrawn or an automatic relinquishment of appointment and privileges.

ARTICLE VIII
PROCEDURE FOR QUESTIONS INVOLVING MEDICAL STAFF APPOINTEES

Section 1. Initial Procedure:

Whenever a concern or question has been raised, or where collegial efforts have not resolved an issue, regarding:

(a) the clinical competence or clinical practice of any Medical Staff appointee, including the care, treatment or management of a patient or patients;

(b) the known or suspected violation by any Medical Staff appointee of applicable ethical standards or the Bylaws, policies, Rules or Regulations of the Hospital or the Medical Staff;

(c) conduct on the part of any Medical Staff appointee that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the individual to work cooperatively and harmoniously with others; and/or

(d) any other matter concerning an appointee's qualifications for appointment;

the President of the Medical Staff, clinical department chairperson, chairperson of the Credentials Committee, CPE or CEO shall make sufficient inquiry to satisfy themselves that the concern or question raised is credible, after which it shall be submitted in writing to the Medical Executive Committee. If any of the inquiring individuals set forth in this provision believe it to be in the best interest of the Hospital and the appointee concerned, they may, but are not required to, discuss the matter with the affected individual. No action taken pursuant to this Section shall constitute an investigation.

Section 2. Initiation of Investigation:

(a) When a question involving clinical competence or professional conduct is referred to, or raised by, the Medical Executive Committee, that committee shall review the matter and determine whether to conduct an investigation or direct the matter to be handled pursuant to other applicable policies (e.g., those relating to conduct, sexual

harassment, or physician health). An investigation shall begin only after a formal determination by the Medical Executive Committee to conduct an investigation.

(b) The Medical Executive Committee shall inform the individual that an investigation has begun, unless, in the Committee's judgment, informing the individual would compromise the investigation or disrupt the operations of the Hospital or Medical Staff.

(c) The Board may also determine to begin an investigation, and may delegate the actual investigation to the Medical Executive Committee, a subcommittee of the Board, or an ad hoc committee.

(d) The President of the Medical Staff shall keep the CEO fully informed of all actions taken regarding an investigation.

Section 3. Investigative Procedure:

Once a determination has been made to begin an investigation, the Medical Executive Committee shall meet as soon as possible:

(a) If the concern states sufficient information to warrant a recommendation, the Medical Executive Committee may make a recommendation, with or without a personal interview with the individual being investigated.

(b) If the concern does not state sufficient information to warrant a recommendation, the Medical Executive Committee shall either immediately investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an individual or an ad hoc investigating committee consisting of at least three (3) persons, who may or may not hold appointments to the Medical Staff. This investigating committee shall not include partners, associates, relatives or any individual who is in direct economic competition with the individual being investigated. Whenever the questions raised concern the clinical competence of the individual under review, the investigating committee shall include a peer of the individual (e.g., physician, dentist, podiatrist).

(c) The investigating committee shall have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital and the investigating committee that:

(1) the clinical expertise needed to conduct the review is not available on the Medical Staff; or

(2) the individual under review has raised, or is likely to raise, questions about the objectivity of other Medical Staff members participating in the investigation; or

(3) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, conflicts of interest and/or prejudice, even if such allegations are unfounded.

(d) The investigating committee shall also have the authority to review documents and interview individuals with information, and may also require a physical and/or mental examination of the individual by health care professionals satisfactory to the committee. The results of such examination shall be made available for consideration by the investigating committee.

(e) As a courtesy, the individual being investigated shall have an opportunity to meet with the investigating committee before it makes its report. Prior to the meeting, the individual shall be informed of the general question being investigated, and shall be invited to discuss, explain or refute it. This meeting shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. The individual being investigated shall not be entitled to be represented by legal counsel at this meeting. A summary of the interview shall be made by the investigating committee and included with its report to the Medical Executive Committee.

(f) If an investigating committee is used, the Medical Executive Committee may accept, modify or reject the recommendation it receives from that committee.

(g) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within thirty (30) days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within thirty (30) days of receiving the results of the outside review, and within a total of ninety (90) days to one hundred twenty (120) days of the commencement of the investigation. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the Medical Executive Committee of the reasons for the delay and the approximate date on which it expects to complete the investigation.

(h) At the conclusion of the investigation, the investigating committee shall prepare a report of its findings, conclusions, and recommendations. In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the investigating committee may consider, as appropriate:

(1) relevant literature and clinical practice guidelines;

(2) all of the opinions and views that were expressed throughout the review, including reports from any outside reviews; and

(3) any information or explanations provided by the individual under review.

The report shall be presented to the Medical Executive Committee for further review.

Section 4. Procedure Thereafter:

(a) At the conclusion of the investigation, the Medical Executive Committee may accept, or reject any recommendation it receives from the investigating committee. Specifically, the Medical Executive Committee may:

(1) determine that no action is justified;

(2) issue a letter of guidance or counsel;

(3) issue a written warning or reprimand;

(4) impose conditions for continued appointment;

(5) impose a requirement for monitoring or consultation;

(6) recommend additional training or education;

(7) recommend reduction of clinical privileges;

(8) recommend suspension of clinical privileges for a term;

(9) recommend revocation of appointment and/or clinical privileges; or

(10) make such other recommendations as it deems necessary or appropriate.

(b) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff leaders on an ongoing basis through the performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

(c) Any recommendation by the Medical Executive Committee that would entitle the individual to request a hearing shall be forwarded to the CEO who shall promptly notify the affected individual in writing, certified mail, return receipt requested. The CEO will then hold the recommendation until after the individual has

completed or waived the right to a hearing and appeal. Thereafter, the CEO shall forward the recommendation of the Medical Executive Committee, together with all supporting information, to the Board (or the Executive Committee of the Board). The Chairperson of the Medical Executive Committee shall be available to the Board (or the Executive Committee of the Board) to answer any questions that may be raised with respect to the recommendation.

(d) If the action of the Medical Executive Committee does not entitle the individual to request a hearing, it shall take effect immediately and shall stand unless modified by the Board.

(e) In the event the Board considers a modification to the recommendation of the Medical Executive Committee that would entitle the individual to request a hearing, the CEO shall notify the individual in writing, certified mail, return receipt requested. No final action shall be taken until the individual has completed or waived the right to a hearing and appeal.

ARTICLE IX

HEARING AND APPEAL PROCEDURES

Part A. Initiation of Hearing:

Section 1. Grounds for Hearing:

(a) An applicant or an individual holding a Medical Staff appointment shall be entitled to request a hearing whenever one (1) of the following adverse professional review recommendations has been made by the Medical Executive Committee or the Board:

(1) denial of initial Medical Staff appointment;

(2) denial of Medical Staff reappointment;

(3) revocation of Medical Staff appointment;

(4) denial of requested initial clinical privileges;

(5) denial of requested additional clinical privileges;

(6) decrease of clinical privileges;

(7) suspension of clinical privileges (other than precautionary suspension);

(8) imposition of mandatory concurring consultation requirement; or

(9) denial of reinstatement from a leave of absence, or imposition of modifications of privileges or conditions for reinstatement, if a report to the National Practitioner Data Bank is required.

(b) No other professional review recommendations except those enumerated in (a) of this Section shall entitle the individual to request a hearing.

(c) The affected individual shall also be entitled to request a hearing before the Board enters a final decision, in the event the Board should determine, without a similar adverse recommendation from the Medical Executive Committee, to take any action set forth above.

(d) The hearing shall be conducted in as informal a manner as possible, subject to the provisions of these Bylaws.

(e) Residents in training at the Hospital shall not be entitled to the hearing and appeal rights set forth in these Bylaws. All resident grievances shall be addressed pursuant to those procedures outlined in the resident contract and/or the resident's training manual.

<u>Section 2. Actions Not Grounds for Hearing:</u>

None of the following actions constitute grounds for a hearing. These actions take effect without hearing or appeal. The individual is entitled to submit a written statement regarding these actions for inclusion in his or her file.

(a) a letter of guidance, counsel, warning, or reprimand;

(b) conditions, monitoring, proctoring, or a general consultation requirement;

(c) a lapse, withdrawal of or decision not to grant or not to renew temporary privileges;

(d) appointment or reappointment for less than two (2) years;

(e) automatic relinquishment of appointment or privileges (entitles the individual to the hearing rights set for in Article VII, Part E, Section 8;

(f) a requirement for additional training or continuing education;

(g) precautionary suspension (entitles the individual to request the hearing rights set forth in Article VII, Part D, Section 2);

(h) denial of a request for leave of absence or for an extension of a leave;

(i) removal from the on-call roster or any reading or rotational panel;

(j) the voluntary acceptance of a performance improvement plan option;

(k) determination that an application is incomplete;

(l) determination that an application will not be processed due to a misstatement or omission; or

(m) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

Part B. The Hearing:

Section 1. Notice of Recommendation:

When a recommendation is made which entitles an individual to request a hearing prior to a final decision of the Board, the CEO shall give notice to the affected individual in writing, by certified mail, return receipt requested, within ten (10) days from the date the recommendation was made. The notice shall contain:

(a) a statement of the adverse professional review recommendation and the general reasons for it;

(b) notice that the individual has the right to request a hearing on the adverse recommendation within thirty (30) days of receipt of this notice; and

(c) a copy of this Article.

Section 2. Request for Hearing:

An individual shall have thirty (30) days following the date of the receipt of the notice within which to request the hearing. The request shall be in writing to the CEO. In the event the individual does not request a hearing within the time and in the manner required by these Bylaws, the individual shall be deemed to have waived the right to the hearing and to have accepted the action involved. That action shall become effective immediately upon final Board action.

Section 3. Notice of Hearing and Statement of Reasons:

(a) The CEO shall schedule the hearing and shall give written notice, certified mail, return receipt requested, to the individual who requested the hearing. The notice shall include:

(1) the time, place and date of the hearing;

(2) a proposed list of witnesses, as known at that time, who will give testimony or present evidence at the hearing regarding the recommendation and a brief summary of the nature of the anticipated testimony;

(3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and

(4) a statement of the specific reasons for the adverse recommendation including, if applicable, a list of patient records and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications. The individual and counsel shall have sufficient time, up to thirty (30) days, to study this additional information.

(b) The hearing shall begin as soon as practicable, but no sooner than thirty (30) days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties.

Section 4. Witness List:

(a) Within ten (10) days after receiving notice of the hearing, the individual requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on the individual's behalf and shall include a brief summary of the nature of the anticipated testimony.

(b) The witness list of either party may, in the discretion of the Presiding Officer or Hearing Panel Chairperson, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The Presiding Officer shall have the authority to limit the number of witnesses, especially character witnesses or witnesses whose testimony is merely cumulative.

Section 5. Hearing Panel, Presiding Officer and Hearing Officer:

(a) Hearing Panel:

The CEO, after consulting with the President of the Medical Staff, will appoint a Hearing Panel in accordance with the following guidelines:

(i) The Hearing Panel will consist of at least three members, one of whom will be designated as chairperson.
(ii) The Hearing Panel may include any combination of:
  (a) any member of the Medical Staff, or
  (b) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital).

(iii) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Hearing Panel.

(iv) Employment by, or other contractual arrangement with, the Hospital or an affiliate will not preclude an individual from serving on the Panel.

(v) The Hearing Panel will not include any individual who:

(c) is in direct economic competition with the individual requesting the hearing;

(d) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

(e) actively participated in the matter at any previous level.

(b) Presiding Officer:

(1) In lieu of a Hearing Panel Chairperson, the CEO may appoint an active or retired attorney at law as Presiding Officer. The Presiding Officer shall not act as a prosecuting officer, or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

(2) If no Presiding Officer has been appointed, a Chairperson of the Hearing Panel shall serve as the Presiding Officer and shall be entitled to one (1) vote.

(3) The Presiding Officer (or Hearing Panel Chairperson) shall:

(i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present oral and documentary evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

(ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, abusive or that causes undue delay;

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure throughout the hearing;

(v) have the authority and discretion to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence;

(vi) make certain that all information relevant to the appointment or clinical privileges of the individual requesting the hearing is presented to the Hearing Panel; and

(vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

(4) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, the CEO, after consulting with the President of the Medical Staff (and Chairperson of the Board if the hearing was occasioned by a Board determination), may appoint a Hearing Officer to perform the functions that would otherwise be carried out by a Hearing Panel. The Hearing Officer shall preferably be an attorney at law.

(2) The Hearing Officer may not be in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she must not represent clients in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

(d) Compensation:

Members of the Hearing Panel, the Presiding Officer, or the Hearing Officer may be compensated for their service by the Hospital. The individual requesting the hearing may contribute to that compensation. Compensation shall not constitute grounds for challenging the impartiality of the Hearing Panel members.

(e) Objections:

Any objection to any member of the Hearing Panel, or the Hearing Officer, or the Presiding Officer, shall be made in writing within ten (10) days of receipt of notice to the CEO, who shall resolve the objection.

(f) Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be attorneys at law licensed to practice, in good standing, in any state.

Part C. Hearing Procedure:

Section 1. Discovery:

(a) There is no right to discovery in connection with the hearing. However, the affected individual shall be entitled, upon specific written request, to the following, provided that the written request must state that all documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:

(1) copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at the individual's expense;

(2) reports of experts relied upon by the Medical Executive Committee or the Board;

(3) redacted copies of relevant committee or clinical department meeting minutes (such provision is not intended to constitute a waiver of the state peer review protection statute); and

(4) copies of any other documents relied upon by the Medical Executive Committee (or the Board).

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

(b) The affected individual shall have no right to discovery beyond the above information. No information shall be provided regarding other Medical Staff appointees.

(c) Prior to the hearing, on dates set by the Presiding Officer or agreed upon by counsel for both sides, each party shall provide the other with a list of proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the hearing. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(d) Prior to the hearing, on dates set by the Presiding Officer, the individual requesting the hearing shall, upon specific request, provide the Medical Executive Committee (or the Board) copies of any expert report or other documents relied upon by the individual.

(e) Neither the affected individual, nor his or her attorney, nor any other person on behalf of the affected individual, shall contact Hospital employees appearing on the Hospital's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

(f) Neither the Hospital nor its attorney nor any other person on behalf of the Hospital shall contact those persons appearing on the affected individual's witness list concerning the subject matter of the hearing, unless such witness is also listed as a witness for the Hospital or unless specifically agreed upon by counsel.

Section 2. Pre-Hearing Conference:

The Presiding Officer may require counsel or other representative for the individual and for the Hospital's Executive Committee (or the Board) to participate in a pre-hearing conference for purposes of resolving all procedural questions in advance of the hearing. The Presiding Officer may specifically require that:

(a) all documentary evidence be exchanged by the parties prior to this conference and any objections to the documents be made at this conference and be resolved by the Presiding Officer;

(b) evidence unrelated to the reasons for the adverse recommendation or unrelated to the individual's qualifications for appointment or the relevant clinical privileges be excluded;

(c) any objections regarding witnesses be made at this conference and resolved by the Presiding Officer;

(d) the time granted to each witness' testimony and cross-examination be agreed upon, or determined by the Presiding Officer, in advance; and

(e) witnesses and documentation not provided and agreed upon in advance of the hearing shall be excluded from the hearing, except upon a showing of good cause.

Section 3. Failure to Appear:

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall constitute voluntary acceptance of the pending adverse professional review recommendation, which shall then be forwarded to the Board for final action.

Section 4. Record of Hearing:

The Hearing Panel shall maintain a record of the hearing by a stenographic reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the Hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this State.

Section 5. Rights of Both Sides:

(a) At a hearing both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

(3) to cross-examine any witness on any matter relevant to the issues;

(4) representation by counsel who may call, examine, and cross-examine witnesses and present the case;

(5) to submit a written statement at the close of the hearing; and

(6) to submit proposed findings, conclusions and recommendations to the Hearing Panel.

(b) Any individual requesting a hearing who does not testify in his or her own behalf may be called and questioned as if under cross-examination.

(c) The Hearing Panel may question the witnesses, call additional witnesses or request additional documentary evidence.

Section 6. Order of Presentation:

The Medical Executive Committee or the Board, depending on whose recommendation prompted the hearing initially shall first present evidence in support of its recommendation. Thereafter, the burden will shift to the individual who requested the hearing to present evidence.

Section 7. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Hearsay evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

Section 8. Post-Hearing Statement:

Each party shall have the right to submit a written statement and the Hearing Panel may request such a statement to be filed, following the close of the hearing.

Section 9. Observers:

The hearing shall be restricted to those individuals involved in the proceeding. Appropriate administrative personnel may be present as requested by the CEO and the President of the Medical Staff.

Section 10. Postponements and Extensions:

Postponements and extensions of time beyond any time limit set forth in these Bylaws may be requested by anyone but shall be permitted only by the Presiding Officer or the CEO, on a showing of good cause.

Part D. Hearing Conclusion, Deliberations and Recommendations:

Section 1. Basis of Recommendation:

(a) The Hearing Panel shall recommend in favor of the Executive Committee (or the Board) unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the adverse recommendation that prompted the hearing was arbitrary, capricious, or not supported by substantial, credible evidence.

(b) The recommendation of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

(1) oral testimony of witnesses;

(2) post-hearing statements;

(3) any information regarding the individual who requested the hearing so long as that information has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it;

(4) any and all applications, reference evaluations, and accompanying documents;

(5) medical records; and

(6) any other information presented at the hearing.

Section 2. Adjournment and Conclusion:

The Presiding Officer may adjourn the hearing and reconvene it at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and/or questions by the Hearing Panel, the hearing shall be closed.

Section 3. Deliberations and Recommendation of the Hearing Panel:

Within twenty (20) days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer, and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons for the recommendation.

Section 4. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report and recommendation to the CEO, who shall forward it, along with all supporting documentation, to the Board for further action. The CEO shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the Medical Executive Committee for information and comment.

Part E. Appeal Procedure:

Section 1. Time for Appeal:

Within ten (10) days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, and must include a statement(s) of the reasons for appeal and the specific facts or circumstances which justify further review. The request shall be delivered to the CEO either in person or by certified mail, return receipt requested. If an appeal is not requested in writing within ten (10) days, the opportunity to appeal shall be deemed to be waived, and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

Section 2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(a) there was substantial failure to comply with these Bylaws and/or the Hospital or Medical Staff Bylaws during or prior to the hearing so as to deny a fair hearing; and/or

(b) the recommendations of the Hearing Panel were made arbitrarily, capriciously or with prejudice; and/or

(c) the recommendations of the Hearing Panel were not supported by substantial evidence.

Section 3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding sections, the Chairperson of the Board shall, as soon as arrangements can reasonably be made, taking into account the

schedules of all participants, schedule and arrange for an appeal. The affected individual shall be given notice of the time, place and date of the appeal. When a request for an appeal is from an individual who is under a suspension, the Review Panel shall be convened not more than fourteen (14) days from the date of receipt of the request for an appeal unless the individual agrees to a longer period. The time for an appeal may be extended by the Chairperson of the Board for good cause.

Section 4. Nature of Appellate Review:

(a) The Chairperson of the Board shall appoint a Review Panel composed of not less than three (3) persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, or the Board may hear the appeal as a whole body.

(b) The Review Panel may in its discretion accept additional oral or written evidence subject to the same rights of cross-examination provided at the hearing only if the party seeking to admit it can demonstrate that it is new, relevant evidence not previously available or that a request to admit it at the hearing was denied.

(c) Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed thirty (30) minutes. The Review Panel shall recommend final action to the Board.

(d) The Board may affirm, modify or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges.

Section 5. Appellate Review in the Event of Board Modification or Reversal of Hearing Panel Recommendation:

In the event the Board determines to modify or reverse the recommendation of a Hearing Panel in a matter in which the individual did not request appellate review pursuant to Article IX, Part E, Section 1, and such action would adversely affect the individual, the Board shall notify the affected individual through the CEO that he or she may appeal the proposed modification or reversal. The Board shall take no final professional review action until the individual has completed or waived the procedural rights provided in this Part.

Section 6. Final Decision of the Board:

Within thirty (30) days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing, including specific reasons, and shall deliver copies to the affected individual and to the Chairperson of the Medical Executive Committee, in person or by certified mail, return receipt requested.

Section 7. Further Review:

Except where the matter is referred for further action and recommendation in accordance with Article IX, Part E, Section 4, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board shall in no event exceed thirty (30) days except as the parties may otherwise agree.

Section 8. Right to One Hearing and One Appeal Only:

No applicant or Medical Staff appointee shall be entitled to more than one (1) hearing and one (1) appeal on any matter. If the Board denies initial Medical Staff appointment or reappointment, or revokes or terminates the Medical Staff appointment and/or clinical privileges of a current appointee, that individual may not apply for staff appointment or for those clinical privileges for a period of three (3) years unless the Board provides otherwise.

Section 9. Legal Actions:

If, despite this Article, an individual institutes legal action challenging any credentialing, privileging, peer review, or other professional review action or activity and does not prevail, he or she will reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including costs and attorney's fees, and expert witness fees.

ARTICLE X

ALLIED HEALTH PROFESSIONALS

Part A. Scope and Overview:

Section 1. Scope of Policy and Categories of Allied Health Professionals:

(a) These Bylaws address those allied health professionals who are permitted to practice or provide services at the Hospital and its facilities (Appendix A).

(b) Only those classes of allied health professionals that have been approved by the Board shall be permitted to practice at the Hospital. When the Board determines that there is a need for the services of a particular type of allied health professional and decides to permit those allied health professionals to practice in the Hospital, the Board, in consultation with the Medical Staff, shall amend existing Bylaws or adopt a separate policy that establishes the minimum qualifications that must be demonstrated by such individuals, as well as the authorized privileges or scope of practice and supervision/collaboration requirements, if applicable, for those professionals in the Hospital.

(c) These Bylaws set forth the credentialing processes for allied health professionals at the Hospital, as well as the general practice parameters for these individuals.

(d) Current listings of the specific categories of allied health professionals functioning in the Hospital are attached to these Bylaws as Appendix A. The Appendix may be modified or supplemented by action of the Board, after receiving the recommendation of the Medical Executive Committee, without the necessity of further amendment of these Bylaws.

(e) These Bylaws shall be supplemented by separate policies as referenced in paragraph B above. These separate policies shall set forth: (1) any specific qualifications and/or training that the allied health professional must possess beyond those set forth in these Bylaws; (2) a detailed description of the allied health professional's authorized clinical privileges or scope of practice; (3) any specific conditions that apply to the allied health professional's functioning within the Hospital; and (4) all supervision/collaboration requirements, if applicable.

Section 2. Process for Determining Need for a New Category of Allied Health Professionals:

(a) Whenever an allied health professional requests to practice at the Hospital and the Board has not already approved that specific category of practitioner, the CEO shall refer the matter to the Allied Health Professionals Review Panel to evaluate the need for that specific category of allied health professionals. The Allied Health Professionals Review Panel shall report to the Medical Executive Committee, which shall make a recommendation to the Board for final action.

(b) As part of the process of determining need, the allied health professional shall be invited to submit information about the nature of the proposed practice, the reason access to the Hospital is sought, and the potential benefits to the community of having such services available at the Hospital.

(c) The Allied Health Professionals Review Panel may consider the following factors when making a recommendation as to the need for the services of a specific category of allied health professionals:

(1) the nature of the services that would be offered;

(2) any state license or regulation which outlines the specific patient care services and/or activities that the allied health professionals are authorized by law to perform;

(3) any state "nondiscrimination" or "any willing provider" laws that would apply to the allied health professionals;

(4) the patient care objectives of the Hospital, including patient convenience;

(5) the community's needs and whether those needs are currently being met or could be better met if the services offered by the allied health professionals were provided at the Hospital;

(6) the type of training that is necessary to perform the services that would be offered and whether there are individuals with more training currently providing those services;

(7) the availability of supplies, equipment, and other necessary Hospital resources;

(8) the need for, and availability of, trained staff to support the services that would be offered; and

(9) the ability to appropriately supervise performance and monitor quality of care.

Section 3. Additional Recommendations:

(a) If the Allied Health Professionals Review Panel makes a recommendation that there is a need for the particular category of allied health professionals at the Hospital, it shall also recommend:

(1) any specific qualifications and/or training that must be possessed beyond those set forth in these Bylaws;

(2) a detailed description of a scope of practice or clinical privileges;

(3) any specific conditions that apply to practice within the Hospital; and

(4) any supervision/collaboration requirements, if applicable.

(b) In developing such recommendations, the Allied Health Professionals Review Panel shall consult the appropriate clinical service chief(s) and consider relevant state law and may contact professional societies or associations. The Allied Health Professionals Review Panel may also recommend the number of allied health professionals that are needed.

Part B. Application:

Section 1. Eligibility Criteria:

To be eligible to apply for initial and continued permission to practice, allied health professionals must, where applicable:

(a) have a current, unrestricted license, certification or registration to practice in this state and have never had a license, certification or registration to practice revoked or suspended;

(b) have a current, unrestricted DEA registration and state controlled substance license;

(c) be board certified by the appropriate nationally-recognized certifying body, as applicable (AHP's credentialed prior to the approval date of this Policy will be grandfathered);

(d) be located (office and residence) within the geographic service area of the Hospital, as defined by the Board, close enough to fulfill responsibilities and provide timely and continuous care for patients in the Hospital;

(e) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;

(f) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse or have been required to pay civil penalties for the same;

(g) have never been and are not currently excluded or precluded from participation in Medicare, Medicaid or other federal or state governmental health care program;

(h) have never had a scope of practice or clinical privileges denied, revoked, restricted, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(i) have never been convicted of, or entered a plea of guilty or no contest to, any felony or any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;

(j) satisfy all additional eligibility qualifications relating to their specific area of practice that may be established by the Hospital; and

(k) have a written agreement (if required) with a supervising/collaborating practitioner, which agreement must meet all applicable requirements of state law and Hospital policy.

Section 2. No Entitlement to Medical Staff Appointment:

(a) Allied health professionals who are applying to practice at the Hospital shall not be eligible for appointment to the Medical Staff, or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.

(b) Allied health professionals shall practice at the Hospital at the discretion of the Board.

(c) Allied health professionals may attend meetings of the Medical Staff and its clinical departments, committees, and panels if invited by the Medical Executive Committee or the presiding officer of a service, section, committee or panel.

Section 3. Factors for Evaluation:

Only those individuals who can document that they are qualified in all regards shall be granted permission to practice. The following factors will be evaluated as applicable, as part of a request for permission to practice:

(a) relevant training, experience, demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;

(c) good reputation and character;

(d) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families and other members of health care teams;

(e) ability to safely and competently perform the clinical privileges or scope of practice requested; and

(f) recognition of the importance of, and willingness to support, the Hospital's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

Section 4. Hospital Employees:

Individuals who are employees of the Hospital shall be governed by such Hospital policies, manuals and descriptions as may be established from time to time by Hospital administration. Where applicable, the CEO or a designee shall consult appropriate Medical Staff appointees including, but not limited to, department chairpersons, and/or committee chairpersons regarding the qualifications of those Hospital employees whose responsibilities require the delineation of clinical privileges or scope of practice.

Section 5. Non-Discrimination Policy:

No individual shall be denied permission to practice at the Hospital on the basis of sex, race, creed, religion, color or national origin, or on the basis of any criteria unrelated to professional qualifications or to the Hospital's purposes, needs and capabilities.

Section 6. Assumption of Duties and Responsibilities:

As a condition of consideration of an application and as a condition of continued permission to practice in the Hospital, all allied health professionals shall assume such reasonable duties and responsibilities as the Allied Health Professionals Review Panel, Credentials Committee, Medical Executive Committee and/or the Board shall require, including:

(a) providing appropriate continuous and timely care and supervision to all patients in the Hospital for whom the individual has responsibility;

(b) abiding by all bylaws and policies of the Hospital, including all bylaws, rules and regulations of the Medical Staff as shall be in force during the time the individual is granted permission to practice in the Hospital;

(c) accepting committee and panel assignments and such other reasonable duties and responsibilities as shall be assigned;

(d) providing to the Hospital, with or without request, and, as it occurs, new or updated information that is pertinent to any question on the application form;

(e) appearing for personal interviews as requested in regard to the application;

(f) abiding by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops, and to perform no activity prohibited by said Directives;

(g) refraining from illegal fee splitting or other illegal inducements relating to patient referral;

(h) refraining from assuming responsibility for diagnoses or care of hospitalized patients for which he or she is not qualified or without adequate supervision/collaboration;

(i) refraining from deceiving patients as to his or her status as an allied health professional;

(j) seeking consultation whenever necessary;

(k) promptly notifying the CEO or a designee, and the Chairperson of the Credentials Committee of any change in eligibility for payments by third-party payors or for participation in Medicare, including any sanctions imposed or recommended by the federal Department of Health and Human Services, and/or the receipt of a PRO

citation and/or quality denial letter concerning alleged quality problems in patient care;

(l) abiding by generally recognized ethical principles applicable to the individual's profession;

(m) participating in quality evaluation and performance improvement activities of the Hospital;

(n) completing, in a timely manner, the medical and other required records for all patients as required by the Medical Staff bylaws, rules and regulations and other applicable policies of the Hospital;

(o) working cooperatively with Medical Staff appointees, other allied health professionals, nurses and other Hospital personnel so as not to adversely affect patient care;

(p) participating in applicable continuing education programs;

(q) constructively participating in the development, review, and revision of clinical protocols and pathways pertinent to his or her specialty, including those related to national patient safety initiatives and core measures;

(r) complying with adopted protocols and pathways or document reasons for variance;

(s) agreeing to immediately submit to a blood and/or urine test, or to a complete physical and/or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and one member of the Administrative team) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leadership; and

(t) agreeing that any misstatement in, or omission from, the application form is grounds for the Hospital to stop processing the application. If permission to practice has been granted prior to the discovery of a misstatement or omission, clinical privileges or scope of practice may be deemed to be automatically relinquished. In either situation, there shall be no entitlement to the procedural rights in these Bylaws. The individual shall be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Allied Health Professionals Review Panel shall review the individual's response and provide a recommendation to the Credentials Committee and Medical Executive Committee. The Medical Executive Committee shall recommend to the Board whether the application should be processed further.

Section 7. Professional Conduct:

(a) Allied health professionals who are granted permission to practice in the Hospital are expected to relate in a positive and professional manner to other health care professionals, and to cooperate and work collegially with the Medical Staff leadership and Hospital administration and personnel. Professional conduct shall also include, but not be limited to, each individual's obligation to present himself or herself at the Hospital physically and mentally capable of providing safe and competent care to patients.

(b) Allied health professionals who are granted permission to practice in the Hospital are expected to wear identification at all times clearly indicating their name and specialty.

Section 8. Requests for Application:

(a) Each allied health professional applicant shall be told by the Medical Staff Office that an application will only be forwarded to an individual who can document that he or she meets the requirements for allied health professionals regarding education, training, licensure, certification and/or experience. If, based upon the Medical Staff Office's inquiry, the individual is eligible for an application, the Medical Staff Office will send the individual an application.

(b) A completed application form with copies of all required documents must be returned to the Medical Staff Office within ninety (90) days if the individual desires further consideration. Individuals who fail to meet the threshold criteria shall not be given an application for allied health professional consideration and shall be so informed.

Section 9. Information to be Submitted with Applications:

(a) Application forms shall be sent from the Medical Staff Office to those individuals who return completed request for application forms and who meet the general qualifications set forth in these Bylaws and the threshold qualifications outlined in these Bylaws relating to their areas of practice.

(b) The application form shall require detailed information concerning the applicant's professional qualifications, including:

(1) the names and addresses of at least two (2) individuals who have had recent experience in observing and working with the applicant, and who can provide adequate information pertaining to the applicant's current professional competence and character;

(2) the names and addresses of the department chairs and/or supervising/collaborating physician(s) at any and all hospitals or other institutions at which the applicant has worked or trained;

(3) information as to whether the applicant's permission to practice and/or hospital or health care facility affiliation has ever been voluntarily or involuntarily relinquished, denied, revoked, suspended, reduced, or not renewed;

(4) information as to whether the applicant has ever voluntarily or involuntarily withdrawn his or her application or resigned before a final decision by a hospital's or health care facility's governing board or designee;

(5) information as to whether the applicant's (a) membership in any local, state, or national professional society, (b) license or certification to practice any profession in any state, or (c) Drug Enforcement Administration certification (if applicable) is, or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, or restricted, or is currently being challenged;

(6) information concerning the applicant's professional liability insurance coverage, including the name of the insurance company, the amount and classification of such coverage, whether said insurance policy covers the clinical privileges or scope of practice the applicant requests, and a consent to the release of information from present and past professional liability insurance carriers. If the applicant is an employee or seeking to become a Hospital employee, the Human Resource Department shall consult with the Allied Health Professionals Review Panel concerning the privileges, functions or scope of practice requested;

(7) information concerning the applicant's malpractice litigation experience and/or any professional misconduct proceedings involving the applicant, in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the applicant or the Hospital may deem appropriate;

(8) information concerning the suspension or termination for any period of time of the right or privilege to participate in Medicare, Medicaid, or any other government sponsored program or any private or public medical insurance program;

(9) current information regarding the applicant's ability to perform safely and competently the clinical privileges or scope of practice requested;

(10) information as to whether the applicant has ever been a defendant in a criminal action or convicted of a crime, including details about any such instance;

(11) information regarding the citizenship and/or visa status of the applicant;

(12) the supervising/collaborating physician's registration, if applicable;

(13) the applicant's signature; and

(14) such other information as the Hospital may require.

(c) Any application that does not provide the information requested on the application form shall be deemed incomplete and shall not be considered or processed.

Section 10. Submission of Application:

(a) Completed applications shall be submitted to the Medical Staff Office and must be accompanied by the designated non-refundable processing fee. After reviewing the application to determine that all questions have been answered, and after reviewing all references and other information or materials deemed pertinent, and after verifying the information provided in the application with the primary sources, the Medical Staff Office shall transmit the completed application along with all supporting materials to the Allied Health Professionals Review Panel.

(b) An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied and all information verified. An application shall become incomplete if the need arises for new, additional or clarifying information anytime during the evaluation.

(c) Any application that continues to be incomplete thirty (30) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

Section 11. Burden of Providing Information:

(a) The applicant shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.

(b) The applicant shall have the burden of proving that all the statements made and information given on the application are true and correct. Any misstatement, omission and/or misrepresentation on the application, whether intentional or not, shall constitute cause for immediate cessation of the processing of the application, and no further processing shall occur. In the event that allied health professional status has been granted prior to discovery of such misstatement, misrepresentation

or omission, such discovery shall result in automatic relinquishment of all clinical privileges or scope of practice, and resignation from the allied health professional staff. In either situation, there will be no entitlement to the procedural rights provided in these Bylaws.

Section 12. Grant of Immunity and Authorization to Obtain/Release Information:

By applying for permission to practice, each allied health professional expressly accepts the following conditions during the processing and consideration of the application, whether or not granted, and as an ongoing condition of practice, if granted:

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, any appointee to the Medical Staff, their authorized representatives, and appropriate third parties for any matter relating to scope of practice or clinical privileges or the individual's qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Hospital, its authorized agents, or appropriate third parties.

(b) Authorization to Obtain Information from Third Parties:

The allied health professional specifically authorizes the Hospital, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for scope of practice or clinical privileges, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for scope of practice, clinical privileges, and/or participation at the requesting organization/facility.

(d) Procedural Rights:

Each allied health professional agrees that the procedural rights set forth in these Bylaws shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(e) Legal Actions:

If, notwithstanding the provisions in this Section, an individual institutes legal action and does not prevail, he or she shall reimburse the Hospital, any appointee to the Medical Staff, and any other agent named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

Part. C. Allied Health Professionals Review Panel:

Section 1. Composition:

(a) The Allied Health Professionals Review Panel shall consist of individuals who are actively interested or experienced in and willing to perform the responsibilities associated with the credentialing and performance improvement reviews of allied health professionals. Permanent members of the committee shall include the President of the Medical Staff or a designee, the Secretary-Treasurer of the Medical Staff, who shall serve as Panel Chairperson, the Chairperson of the Credentials Committee or a designee, one (1) at-large Active Staff appointee appointed by the President of the Medical Staff, the Director of Human Resources or a designee, the Chief Nurse Executive, the Medical Staff Coordinator, and at least two (2) allied health professionals, one (1) each from a different clinical specialty, appointed by the Chief Executive Officer in consultation with the President of the Medical Staff. Rotating members of the panel shall be the relevant clinical department chair(s) or their designee(s) and relevant Hospital department head(s) or nurse manager(s), depending on the type of allied health professional being considered.

(b) Each member of the Allied Health Professionals Review Panel shall be entitled to one (1) vote and shall serve a term of two (2) years.

(c) The Allied Health Professionals Review Panel shall be a review and evaluation body and, unless otherwise specified in these Bylaws, the credentialing functions pertaining to allied health professionals shall be performed by the Allied Health Professionals Review Panel or the Panel Chairperson, and all recommendations shall be forwarded to the Credentials Committee.

(d) The presence of fifty percent (50%) of the total membership of the Allied Health Professionals Review Panel shall constitute a quorum for all actions. Once a quorum is established, the business of the Panel may continue and all actions taken shall be valid and binding even though less than a quorum exists at a later time in the Panel meeting.

Section 2. Duties:

The Allied Health Professionals Review Panel shall:

(a) evaluate and make recommendations to the Board, through the Credentials Committee and Medical Executive Committee, regarding the need for the services that could be provided by classes of allied health professionals that are not currently permitted to practice in the Hospital or its facilities;

(b) develop and recommend policies to the Board, through the Credentials Committee and Medical Executive Committee, for each class of allied health professional permitted by the Board, or its designee, to practice in the Hospital. Such policies shall specify: (1) training, education and experience requirements for applicants, (2) the criteria for a scope of practice or clinical privileges, (3) the scope of practice or clinical privileges to be granted, (4) any specific conditions that apply to the allied health professionals' functioning within the Hospital, (5) any on-going supervision/collaboration requirements, and (6) professional liability insurance requirements;

(c) review the qualifications of all allied health professionals who apply for permission to practice in the Hospital, interview such applicants as may be necessary, and make a written report of its findings and recommendations to the Credentials Committee; and

(d) review, as questions arise, all information available regarding the clinical competence and behavior of allied health professionals currently permitted to practice in the Hospital and, as a result of such review, to make a written report of its findings and recommendations to the Credentials Committee.

Section 3. Meetings, Reports and Recommendations:

The Allied Health Professionals Review Panel shall meet as often as necessary to accomplish its duties, but at least bi-monthly (every other month), shall maintain a permanent record of its proceedings and actions, and shall make a report of its recommendations after each meeting to the Credentials Committee. The Chairperson of the Panel shall be available to meet with the Credentials Committee on all recommendations that the Panel may make.

Part D. Credentialing Procedure:

Section 1. Review Procedure:

(a) The Medical Staff Office shall forward the complete application and all supporting materials to the appropriate Hospital supervisor and/or clinical department chair or a designee who shall examine the application and all supporting information and documentation, and make a written report to the Allied Health Professionals Review Panel regarding the applicant's qualifications for the clinical privileges or

scope of practice requested. They may also meet with the applicant and the employing or supervising/collaborating physician, if applicable, to discuss any aspect of the applicant's qualifications to perform the privileges or scope of practice requested.

(b) The Allied Health Professionals Review Panel may use the expertise of any individual on the Medical Staff or at the Hospital, or an outside consultant, if additional information is required regarding the applicant's qualifications. In evaluating the application, the Allied Health Professionals Review Panel may also meet with the applicant and, when applicable, the employing or supervising/collaborating physician.

(c) If the Allied Health Professionals Review Panel's initial recommendation is adverse to the applicant, the applicant and, when applicable, the employing or supervising/collaborating physician shall be given the opportunity to meet with the Allied Health Professionals Review Panel before a final recommendation is made. This meeting shall be informal and shall not be considered a hearing. Following this meeting, the Allied Health Professionals Review Panel shall make a recommendation to the Credentials Committee.

(d) All recommendations to grant allied health professional status must specifically state the clinical privileges or scope of practice to be granted, which may be qualified by any probationary or other conditions or restrictions deemed appropriate by the Panel.

(e) At its next regular meeting, after receipt of the written findings and recommendation of the Allied Health Professionals Review Panel, the Credentials Committee shall:

(1) adopt the findings and recommendation of the Panel; or

(2) set forth in its report and recommendation clear and convincing reasons, along with supporting information, for its disagreement with the Panel's recommendation. The Credentials Committee's recommendation shall be forwarded, together with the Panel's findings and recommendation, to the Medical Executive Committee. Thereafter, the recommendation of the Medical Executive Committee shall be forwarded through the CEO to the Board (or the Executive Committee of the Board).

Section 2. Clinical Privileges:

The clinical privileges recommended to the Board shall be based upon consideration of the following:

(a) education, relevant training, experience, demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical

judgment, interpersonal and communication skills, and professionalism with patients, families and other members of the health care team and peer evaluations relating to the same;

(b) ability to perform the privileges requested competently and safely;

(c) information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;

(d) adequate professional liability insurance coverage for the clinical privileges requested;

(e) the Hospital's available resources and personnel;

(f) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(g) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

(h) practitioner-specific data as compared to aggregate data, when available;

(i) morbidity and mortality data, when available; and

(j) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

Section 3. Renewal of Permission to Practice; Submission of Application:

(a) The grant of a scope of practice or the grant of clinical privileges is a courtesy and, if granted, shall be for a period not to exceed two years. A request to renew a scope of practice or clinical privileges shall be considered only upon submission of a completed renewal application.

(b) At least three months prior to the date of expiration of an allied health professional's scope of practice or clinical privileges, the Medical Staff Office shall notify the individual of the date of expiration and provide the individual with a renewal application. A completed renewal application must be returned to the Medical Staff Office within 30 days.

(c) Failure to return a completed application within 30 days shall result in automatic expiration of such scope of practice or clinical privileges at the end of the then current term, unless the application can still be processed in the normal course,

without extraordinary effort on the part of the Medical Staff Office and/or the Medical Staff leaders.

(d) Once an application for renewal of scope of practice or clinical privileges has been completed and submitted to the Medical Staff Office, it shall be evaluated following the same procedures outlined in these Bylaws regarding initial applications.

Section 4. Renewal Process for Allied Health Professionals:

(a) The procedures pertaining to an initial request for a scope of practice, including eligibility criteria and factors for evaluation, shall be applicable in processing requests for renewal.

(b) As part of the process for renewal of clinical privileges, the following factors shall be considered:

(1) an assessment prepared by the applicable clinical department chair;

(2) an assessment prepared by a peer;

(3) an assessment prepared by the applicable Hospital supervisor (i.e., OR supervisor, nursing supervisor);

(4) results of the Hospital's performance improvement and peer review activities, taking into consideration, when applicable, practitioner-specific information concerning other individuals in the same or similar specialty (provided that, other practitioners shall not be identified);

(5) resolution of any verified complaints received from patients or staff; and

(6) any focused professional practice evaluations.

Section 5. Permission to Provide Services:

Each allied health professional is subject to professional review activity and action, and his or her permission to provide designated clinical services or to perform designated clinical functions may be modified, suspended, terminated, revoked or restricted consistent with the procedures set forth in these Bylaws and other relevant Hospital policies. If the affected allied health professional is a Hospital employee, the Hospital shall apply its existing Human Resources policy to address the concern.

Section 6. Procedural Rights for Allied Health Professionals:

(a) Allied health professionals shall not be entitled to the hearing and appeal procedure set forth in the Medical Staff Bylaws documents or the Hospital's corporate bylaws pertaining to Medical Staff appointees.

(b) The clinical privileges granted to those allied health professionals who are employees of the Hospital shall be incident to, and coterminous with, their employment, with no right to request a hearing under these Bylaws. Any grievance process related to Hospital employment shall be conducted pursuant to the Hospital's employment grievance procedure.

(c) In the event the Medical Executive Committee determines that an allied health professional who is not employed by the Hospital should not be granted permission to practice in the Hospital, or that permission is restricted or terminated, the individual shall be notified of the recommendation and the specific reasons for the recommendation and given the opportunity to request a hearing before the adverse recommendation is forwarded to the Board or its designee.

(d) If the individual requests a hearing, it must be made in writing, directed to the CEO, within thirty (30) days after receipt of written notice of the proposed adverse action.

(e) If the request for a hearing is made, the CEO shall appoint a hearing officer to conduct the hearing. The hearing officer may be a physician or an attorney at law, and shall not include anyone who previously participated in the recommendation, or any relatives, practice associates, or direct economic competitor of the allied health professional. If the hearing officer is an attorney, he or she shall not represent individuals who are in direct economic competition with the allied health professional. The hearing shall be convened within thirty (30) days after the request is received, at a time and place agreed upon by the participants.

(f) At the hearing, a representative of the Medical Executive Committee shall first present the reasons for the unfavorable recommendation. The allied health professional shall then be provided an opportunity to present information regarding the recommendation, subject to a determination by the hearing officer that the information is relevant. The hearing officer shall have the discretion to determine the amount of time allotted to the presentation by the representative of the Medical Executive Committee and the allied health professional.

(g) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the hearing officer:

   (1) to call and examine witnesses, to the extent they are available and willing to testify;

   (2) to introduce exhibits;

   (3) to cross-examine any witness on any matter relevant to the issues;

(4) to be represented by counsel who may call, examine, and cross-examine witnesses and present the case; and

(5) to submit a written statement at the close of the hearing.

(h) Any allied health professional requesting a hearing who does not testify in his or her own behalf may be called and questioned as if under cross-examination.

(i) The hearing officer may question the witnesses, call additional witnesses or request additional documentary evidence.

(j) The Medical Executive Committee's recommendation shall be affirmed unless the allied health professional can demonstrate that the Medical Executive Committee's recommendation was arbitrary, capricious or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital shall be the paramount considerations.

(k) The hearing officer shall maintain a record of the hearing by a stenographic reporter. The cost of the reporter shall be borne by the Hospital, but copies of the transcript shall be provided to the allied health professional at his or her expense.

(l) The hearing officer shall prepare a written report and recommendation within twenty (20) days after the conclusion of the proceeding and shall forward it, along with all supporting information, to the CEO. The CEO shall send a copy of the hearing officer's written report and recommendation, by certified mail, return receipt requested, to the allied health professional.

(m) If the recommendation of the hearing officer is unfavorable, the allied health professional may appeal that recommendation in writing to the CEO within ten (10) days after notice of such recommendation. The request must include a statement of the reasons, including specific facts which justify an appeal. The grounds for appeal shall be limited to the following: (i) there was substantial failure to comply with these Bylaws or other applicable policies of the Hospital, or (ii) the adverse recommendation was arbitrary, capricious or not supported by substantial evidence. The request shall be delivered to the CEO either in person or by certified mail. If a written request for appeal is not submitted within the ten (10) day time frame specified, the recommendation and supporting information shall be forwarded by the CEO to the Board (or the Executive Committee of the Board) for final action.

(n) If a timely request for appeal is submitted, the CEO shall forward the report and recommendation, the supporting information and the request for appeal to the Board Chairperson or a designee, who shall appoint a Board subcommittee of three (3) members to consider the record upon which the hearing officer's adverse recommendation was made, and to make a final decision. New or additional written information that is relevant and could not have been made available to the hearing

officer during the initial review of the matter may be considered in the discretion of this subcommittee.

(o) Upon completion of the review, the Board subcommittee receiving the matter may adopt the recommendation of the hearing officer as its decision or make a different decision. The Board subcommittee is authorized to make a final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital. Such decision shall be deemed to constitute final action by the Board.

(p) Any allied health professional who is denied clinical privileges or permission to practice at the Hospital must wait for a period of two (2) years before reapplying for allied health professional status.

Part E. Conditions of Practice Applicable to Allied Health Professionals:

Section 1. Supervision/Collaboration by Employing or Supervising/Collaborating Physician:

(a) Any activities permitted by the Board to be done at the Hospital by an allied health professional requiring supervision/collaboration shall be done only under the supervision/collaboration of the physician employing or supervising/collaborating with that individual. Except as provided by law or Hospital policy, "supervision" shall not require the actual physical presence of the employing or supervising physician.

(b) Allied health professionals requiring supervision/collaboration may function in the Hospital only so long as they remain employees of, or are supervised by or collaborating with, a physician currently appointed to the Medical Staff. All allied health professionals who are granted a scope of practice or clinical privileges at the Hospital shall be assigned to the same department as their employing or supervising/collaborating physician. Should the Medical Staff appointment or clinical privileges of the staff physician employing an allied health professional requiring supervision/collaboration be revoked or terminated, that individual's permission to practice in the Hospital shall be deemed to be automatically relinquished, resulting in termination without the right to a hearing or meeting as provided in these Bylaws or a grievance hearing as may be provided for Hospital employees. If the Medical Staff appointment or clinical privileges of a physician supervising/collaborating with an allied health professional requiring supervision/collaboration is revoked or terminated, or if the individual's employment is terminated by the employing physician, or if supervision/collaboration is refused by the supervising/collaborating physician, the Allied Health Professionals Review Panel may immediately recommend the termination of the allied health professional's permission to practice in the Hospital, or may recommend that the individual be permitted to arrange for employment or supervision/collaboration by another physician appointed to the Medical Staff.

Section 2. Questions Regarding Authority:

(a) Should any Medical Staff appointee or Hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of an allied health professional either to act or to issue instructions outside the physical presence of the employing, sponsoring or supervising/collaborating physician, that Medical Staff appointee or Hospital employee shall have the right to require that the individual's employer or supervisor validate, either at the time or later, the instructions of the individual. Any act or instruction of the allied health professional shall be delayed until such time as the staff appointee or Hospital employee can be certain that the act is clearly within the scope of the individual's activities as permitted by the Board.

(b) Any question regarding the professional conduct of an allied health professional shall be reported to the appropriate clinical department, the Chairperson of the Allied Health Professionals Review Panel and/or the CEO. At all times the employing or supervising/collaborating physician shall remain responsible for the allied health professional requiring supervision/collaboration while at the Hospital.

Section 3. Responsibilities of Employing, Sponsoring, or Supervising/Collaborating Physicians:

(a) The number of allied health professionals acting as employees of or under the supervision/collaboration of one (1) physician, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations, the rules and regulations of the Medical Staff, and the regulations and policies of the Hospital.

(b) The sponsoring practitioner shall provide oversight for the AHP, as applicable.

ARTICLE XI

HISTORY AND PHYSICAL

1. A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration, but in all cases prior to surgery or an invasive procedure requiring anesthesia services, by an individual who has been granted privileges by the Hospital to perform histories and physicals. The scope of the medical history and physical examination will include, as pertinent:

   (a) patient identification;

   (b) chief complaint;

   (c) history of present illness;

(d) review of systems, to include at a minimum:

   (i) cardiovascular;

   (ii) respiratory;

   (iii) gastrointestinal;

   (iv) neuromusculoskeletal; and

   (v) skin;

(e) personal medical history, including medications and allergies;

(f) family medical history;

(g) social history, including any abuse or neglect;

(h) physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;

(i) data reviewed;

(j) assessments, including problem list;

(k) plan of treatment; and

(l) if applicable, signs of abuse, neglect, addiction or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion will be documented in the plan of treatment.

In the case of a pediatric patient, the history and physical examination report must also include: (i) developmental age; (ii) length or height; (iii) weight; (iv) head circumference (if appropriate); and (v) immunization status.

2. If a medical history and physical examination has been performed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record, provided the patient has been evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first. The update of the history and physical examination must reflect any changes in the patient's condition since the date of the original history and physical or state that there have been no changes in the patient's condition. The update to the history and physical may be included as part of the pre-anesthesia assessment process.

3. When the history and physical examination is not performed or recorded in the medical record before a surgical, diagnostic operative or invasive procedure, the operation or procedure will be canceled unless the attending physician states in writing that an emergency situation exists. If it is an emergency situation and a history and physical has been dictated but has not been transcribed, there will be a statement to that effect in the patient's chart, with an admission note by the attending physician. The admission note must be documented immediately prior to surgery (same day as surgery) and will include, at a minimum, an assessment of the patient's heart rate, respiratory rate and blood pressure.

4. A Short-Form history and physical, containing the chief complaint or reason for the procedure, relevant history of the present illness or injury, and the patient's present clinical condition/physical findings, may be used for ambulatory or same-day procedures as approved by the Medical Executive Committee.

5. The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the admitting physician's office record transferred to the Hospital before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

6. Non-Privileged Practitioners. If a history and physical was performed within 30 days prior to admission by an individual who has not been granted clinical privileges to do so by the Hospital, it may be used as long as, at the time of admission, an individual who has been granted the appropriate privileges by the Hospital: (i) reviews the history and physical, (ii) conducts a second assessment to confirm the information and findings, (iii) updates information as needed, and (iv) signs, dates, and times the updated history and physical.

ARTICLE XII

AMENDMENTS

Part A. Medical Staff Bylaws:

1. Amendments to these Bylaws may be proposed by a petition signed by 25% of the voting members of the Medical Staff, by the Bylaws Committee, or by the Medical Executive Committee.

2. All proposed amendments must be reviewed by the Medical Executive Committee prior to a vote by the Medical Staff. The Medical Executive Committee shall provide notice of all proposed amendments, to the voting staff, including any amendments proposed by the voting members of the Medical Staff. The Medical Executive Committee may also report on any proposed amendments, either favorably or unfavorably, at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose.

3. The proposed amendments may be voted upon at any Medical Staff meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a two-thirds majority of the votes cast by the voting staff at the meeting.

4. The Medical Executive Committee may also present any proposed amendments to the voting staff by written or electronic ballot, returned to the Medical Staff Office by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a two-thirds majority of the votes cast.

5. The Medical Executive Committee shall have the power to adopt such amendments to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.

6. All amendments shall be effective only after approval by the Board.

7. If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request.

Part B. Other Medical Staff Documents:

1. In addition to the Medical Staff Bylaws, there shall be policies, procedures, and Rules and Regulations that are applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures, and rules and regulations shall be considered an integral part of the Medical Staff Bylaws, but amended in accordance with this Section.

2. An amendment to the Policy on Allied Health Professionals may be made by a majority vote of the members of the Medical Executive Committee, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Medical Executive Committee. Notice of all proposed amendments to these documents shall be provided to each voting member of the Medical Staff at least 60 days prior to the vote by the Medical Executive Committee. Any voting member may submit written comments on the amendments to the Medical Executive Committee.

3. An amendment to the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Medical Executive Committee. Notice of all proposed amendments to the Rules and Regulations shall be provided to each voting member of the Medical Staff at least 14 days prior to the vote by the Medical Executive Committee. Any voting member may submit written comments on the amendments to the Medical Executive Committee.

4. The Medical Executive Committee and the Board shall have the power to provisionally adopt urgent amendments to the Medical Staff Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member of the Medical Staff as soon as possible. The Medical Staff shall have 14 days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendments shall stand. If there is conflict

over a provisional amendment, then the process for resolving conflicts set forth below shall be implemented.

5. All other policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Executive Committee. No prior notice is required.

6. Amendments to Medical Staff policies, manuals and Rules and Regulations may also be proposed by a petition signed by a majority of the voting members of the Medical Staff. Notice of any such proposed amendment to these documents shall be provided to each voting member of the Medical Staff 14 days in advance of forwarding the proposed recommendation to the Medical Executive Committee. Any such proposed amendments will be reviewed by the Medical Executive Committee, which may comment on the amendments before they are forwarded to the Board for its final action.

7. Adoption of and changes to these Bylaws, the Medical Staff Rules and Regulations, and other Medical Staff policies and manuals will become effective only when approved by the Board.

8. The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present rule or regulation is inconsistent with these Bylaws, it is of no force or effect.

Part C. Conflict Management Process:

1. When there is a conflict between the Medical Staff and the Medical Executive Committee with regard to:

   (a) proposed amendments to the Medical Staff Rules and Regulations,

   (b) a new policy proposed by the Medical Executive Committee, or

   (c) proposed amendments to an existing policy that is under the authority of the Medical Executive Committee,

   a special meeting of the Medical Staff will be called. The agenda for that meeting will be limited to the amendment(s) or policy at issue. The purpose of the meeting is to resolve the differences that exist with respect to Medical Staff Rules and Regulations or policies.

2. If the differences cannot be resolved at the meeting, the Medical Executive Committee shall forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies offered by the voting members of the Medical Staff, to the Board for final action.

3. This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review activities or actions concerning individual members of the Medical Staff.

APPENDIX A

Those allied health professionals currently practicing at Sacred Heart Hospital are as follows:

Psychologists
Certified Nurse Midwife
Certified Physician Assistant
Certified Registered Nurse Anesthetist (CRNA)
Nurse Practitioner
Surgical First Assist