MEDICAL STAFF BYLAWS

HSHS HOLY FAMILY HOSPITAL
GREENVILLE, ILLINOIS
an Affiliate of
Hospital Sisters Health System

MEDICAL STAFF BYLAWS

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While Bylaws and Credentials Policies are in process of revisions the table of contents will not be updated until final revisions are completed.

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PURPOSE:

The Medical Staff Bylaws shall set forth the core membership requirements, organizational and leadership structure, and due process rights and procedures, of Medical Staff membership at HSHS Holy Family Hospital.

ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in the Medical Staff documents are set forth in the Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in these Bylaws and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated. Medical Staff leaders will strive to be fair under the circumstances.

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of the Hospital Management, a Medical Staff Member, or by a Medical Staff committee, the individual, or the committee through its Chair, may delegate performance of the function to one or more designees.

(2) When a Medical Staff Member is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.D. MEDICAL STAFF DUES

(1) Medical Staff dues, if implemented, will be as recommended by the Medical Staff Executive Committee and may vary by category.

(2) Dues will be payable annually upon request. Failure to pay dues will result in ineligibility for continued appointment and privileges.

(3) Signatories to the Hospital's Medical Staff account will be Secretary/Treasurer, and Vice President or President.

1.E. INDEMNIFICATION WHEN PERFORMING CREDENTIALING AND PEER REVIEW FUNCTIONS

The Hospital will provide a legal defense for, and will indemnify, Medical Staff officers, department chairs, Medical Staff 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 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff and Allied Health Staff set forth in the Bylaws or Bylaws-related documents are eligible to apply for appointment to one of the categories listed below.

2.A. ACTIVE STAFF

2.A.1. Qualifications:

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

a) are involved in at least 24 unique patient contacts over a 24-month period; and

b) are willing to participate in Medical Staff functions and/or demonstrate a commitment to the Medical Staff and Hospital through service on hospital or Medical Staff committees and/or active participation in performance improvement or professional practice evaluation functions.

Guidelines:

Unless an Active Staff member can demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that their practice patterns have changed and that they will satisfy the activity requirements of this category:

* Any member who has fewer than 24 patient contacts per 24-month appointment term will not be eligible to request Active Staff status at the time of their reappointment.

** The member must select and be transferred to another staff category that best reflects their relationship to the Medical Staff and the Hospital (options – Courtesy, Consulting, Coverage or Affiliate).

2.A.2. Prerogatives and Responsibilities:

Active Staff Members:

a) may admit patients, in accordance with the member's admitting privileges, except as otherwise provided in the Bylaws or Bylaws-related documents, or as limited by the Board;

b) may vote in all general and special meetings of the Medical Staff and applicable department and committee meetings by any method (e.g., email, mail, ballot, facsimile) designated in a notice presenting a question for vote;

c) may hold office, serve on Medical Staff committees, and serve as department chairperson and chairperson of committees ; and

d) may exercise clinical privileges granted.

Active Staff Members must assume all the responsibilities of the Active Staff, including:

a) serving on committees, as requested;

b) providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department;

c) providing care for unassigned patients;

d) participating in the professional practice evaluation and performance Finalimprovement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their specialties);

e) accepting inpatient consultations, when requested;

f) must pay all applicable application fees, dues, and assessments; and

g) shall perform assigned duties.

Members of the Active Staff who are 65 years of age or older may request to be excused from rotational obligations, including providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department. The request will be reviewed by the Medical Staff Department Chair, and a recommendation made to the Medical Staff Executive Committee and final action by the Board. In reviewing a request, consideration should be given to need and the effect on others who serve on the Emergency Department call roster. A member who is relieved of the obligation of providing coverage may be required to resume on-call duties if the Medical Staff Department determines, later, that call coverage in the member's specialty area is not adequate.

2.B. COURTESY STAFF

2.B.1. Qualifications:

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

a) are involved in fewer than 24 unique patient contacts over a 24-month period;

b) at each reappointment time, provide quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

Guidelines:

Unless a Courtesy Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that their practice patterns have changed and that they will satisfy the activity requirements of this category:

* Any member who has more than 24 patient contacts per 24-month period will be transferred to Active Staff status.

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff Members:

a) may admit patients in accordance with clinical privileges granted;

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

c) may not hold office or serve as department chairperson or committee chairperson, unless waived by the Medical Staff Executive Committee and the Board;

d) may exercise clinical privileges granted;

e) may be invited to serve on committees (with vote);

f) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but will be required to provide specialty coverage if the Medical Staff Executive Committee finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

g) must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department physician;

h) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department;

i) must cooperate in the professional practice evaluation and performance improvement processes;

j) must pay any applicable application fees, dues, and assessments; and

k) shall perform assigned duties.

2.C. CONSULTING STAFF

2.C.1. Qualifications:

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

a) demonstrate professional ability and expertise and provide a service not otherwise available (or is in very limited supply) on the Active or Courtesy Staff;

b) provide services at the Hospital only at the request of other members of the Medical Staff;

c) at each reappointment time, provide quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

2.C.2. Prerogatives and Responsibilities:

Consulting Staff Members:

a) may evaluate and treat, but not admit or provide overall patient management for, patients in conjunction with other members of the Medical Staff;

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

c) may not hold office, serve as department chairperson or committee chairperson, unless waived by the Medical Staff Executive Committee and the Board;

d) may exercise clinical privileges granted;

e) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but will be required to provide specialty coverage if the Medical Staff Executive Committee finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

f) must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department physician;

g) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department;

h) must cooperate in the professional practice evaluation and performance improvement processes;

i) must pay any applicable application fees, dues, and assessments; and

j) shall perform assigned duties.

2.D. COVERAGE STAFF

2.D.1. Qualifications:

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

a) desire appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Medical Staff members who are members of their group practice or their coverage group;

b) at each reappointment time, provide quality data and other information to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians). as set forth in the Credentials Policy; and

c) agree that their Medical Staff appointment and clinical privileges will be automatically relinquished, with no right to a hearing or appeal, if their coverage arrangement with the Medical Staff member(s) terminates for any reason.

2.D.2. Prerogatives and Responsibilities:

Coverage Staff Members:

a) when providing coverage assistance to a Medical Staff member, will be entitled to admit and/or treat patients who are the responsibility of the Medical Staff member who is being covered (i.e., the Active, Courtesy or Consulting Staff member's own patients or unassigned patients who present through the Emergency Department when the Medical Staff member is on call), if applicable;

b) will assume all Medical Staff functions and responsibilities as may be assigned, including, where appropriate, emergency service care, consultation, and teaching assignments when covering for members of their group practice or coverage group;

c) may attend Medical Staff and department meetings (without vote); and applicable committee meetings (with vote);

d) must cooperate in the professional practice evaluation and performance improvement processes.

e) may not hold office or serve as department chairperson or committee chairperson;

f) generally have no staff committee responsibilities, but may be assigned to committees (with vote); and

g) may exercise clinical privileges granted;

h) must pay any applicable application fees, dues, and assessments; and

i) shall perform assigned duties.

2.E. AFFILIATE STAFF

2.E.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 and wish to be membership-only category, with no clinical privileges being granted;

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

c) are permitted to access hospital services for patients by referral of patients to Active Staff members for admission and care; and

d) must submit an application as prescribed by the Bylaws or Bylaws-related documents excluding privileges, satisfy the qualifications for appointment set forth in the Bylaws or Bylaws-related documents, but are exempt from the qualifications pertaining to response times, location within the geographic service area, emergency call, and coverage arrangements.

2.E.2. Prerogatives and Responsibilities:

Affiliate Staff Members:

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

b) may not hold office or serve as department chairperson or committee chairperson;

c) shall generally have no staff committee responsibilities, but may be assigned to serve on committees (with vote), including serving as committee chair;

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

e) may refer patients to members of the Medical Staff for admission and/or care;

f) are encouraged to communicate directly with members of the Medical Staff about the care of any patients referred, as well as to visit any such patients who are hospitalized; and record a courtesy progress note in the medical record containing relevant information from the patient's outpatient care;

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

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

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

j) may refer patients to the Hospital's diagnostic facilities subject to the rules and policies of the hospital and the clinical departments; and order such tests;

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

l) must pay any applicable application fees, dues, and assessments.

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

2.F. TELEMEDICINE (Non-Staff)

2.F.1. Qualifications:

The Telemedicine (Non-Staff) providers will consist of providers who provide care, evaluation and treatment of patients only remotely via electronic communication, or sorely for the interpretation of diagnostic services.

a) at each reappointment time, provide quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

2.F.2. Prerogatives and Responsibilities:

Telemedicine (Non-Staff) Members:

a) may evaluate and treat (but not admit or provide overall patient management for) patients in conjunction with other members of the Medical Staff.

b) may not hold office or serve as department chairperson or committee chairperson, unless waived by the Medical Staff Executive Committee and the Board;

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

d) may be invited to serve on committees (with vote);

e) must participate in providing emergency department on-call and other coverage arrangements as defined by policy and/or contractual agreements;

f) must cooperate in the professional practice evaluation and performance improvement processes;

g) may exercise clinical privileges granted;

h) must pay any applicable application fees, dues, and assessments; and

i) shall perform assigned duties.

2.G. HONORARY STAFF

2.G.1. Qualifications:

The Honorary Staff will consist of members of the Medical Staff and Allied Health Staff who:

a) 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 Staff Executive Committee, are in good standing at the time of initial application for membership on the Honorary Staff; and/or

b) are recognized for outstanding or noteworthy contributions to the medical sciences.

Once an individual is appointed to the Honorary Staff, that status is ongoing, at the continuing discretion of the Medical Staff Executive Committee. As such, there is no need for the individual to submit a reappointment application.

2.G.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 chairperson or committee chairperson;

d) may be appointed to committees (without vote);

e) are entitled to attend educational programs of the Medical Staff and the Hospital; and

f) are not required to pay application fees, dues, or assessments.

2.H. ALLIED HEALTH STAFF

2.H.1. Qualifications:

The Allied Health Staff consists of Allied Health Professionals who are granted clinical privileges and are appointed to the Allied Health Staff. The Allied Health Staff is not a category of the Medical Staff but is included in this Article for convenient reference.

2.H.2. Prerogatives and Responsibilities:

Allied Health Staff Members:

a) may attend and participate in Medical Staff department meetings (without vote);

b) may not hold office or serve as department chairperson or committee chairperson;

c) may be invited to serve on committees (with vote);

d) must cooperate in the professional practice evaluation and performance improvement processes;

e) may exercise clinical privileges or scope or practice as granted; and

f) must pay any applicable application fees, dues, and assessments.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The Medical Staff will have the following officers:

(1) President of the Medical Staff;

(2) Vice President of the Medical Staff; and

(3) Secretary/Treasurer.

3.B. ELIGIBILITY CRITERIA

Only those Members of the Medical Staff who satisfy the following criteria initially and continuously will be eligible to serve as an officer of the Medical Staff (unless an exception is recommended by the Medical Staff Executive Committee and approved by the Board). They must:

(1) currently be a member of the Active Staff and have served on the Active Staff for at least one year;

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

(3) not presently be serving as a Medical staff officer, Board member, or department chair at any other hospital other than one within the system and will not so serve during their terms of office;

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

(5) have experience in a leadership position or other involvement in performance improvement functions for at least one year;

(6) be willing to participate in Medical Staff Leadership training as determined by the Medical Staff Executive Committee;

(7) have demonstrated an ability to work well with others; and

(8) not have any financial relationship (i.e., an ownership or investment interest in or compensation arrangement) with an entity that competes with the Hospital or any

Affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner.

Under exceptional circumstances, the Medical Staff Executive Committee may grant a waiver of one or more of the above eligibility criteria. In making a determination of whether to grant a waiver, the Medical Staff 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 the Medical Staff. No individual is entitled to a waiver or a hearing if the Medical Staff Executive Committee determines not to grant a waiver. The President of the Medical Staff may not simultaneously hold a clinical department chair position. No physician shall simultaneously hold two officer positions.

3.C. DUTIES

3.C.1. President of the Medical Staff:

The President of the Medical Staff will:

(a) act in coordination and cooperation with the Chief Executive Officer and the Board in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies and needs, and report on the activities, of the Medical Staff to Chief Executive Officer and the Board;

(c) call, preside at, and be responsible for the agenda of meetings of the Medical Staff and the Medical Staff Executive Committee;

(d) promote adherence to the Bylaws, policies, rules and regulations of the Medical Staff and to the policies and procedures of the Hospital; and

(e) perform functions authorized in these Bylaws and other applicable policies, including collegial intervention in the Credentials Policy.

3.C.2. Vice President:

The Vice President will:

(a) assume the duties of the President of the Medical Staff and act with full authority as President of the Medical Staff in his/her absence; and

(b) perform other duties as are assigned by the President of the Medical Staff or the Medical Staff Executive Committee.

3.C.3. Secretary/Treasurer:

The Secretary/Treasurer will:

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

(b) oversee the collection of and accounting for any Medical Staff funds and make disbursements authorized by the Medical Staff Executive Committee; and

(c) perform other duties as are assigned by the President of the Medical Staff or the Medical Staff Executive Committee.

3.D. NOMINATION AND ELECTION PROCESS

3.D.1. Nominating Committee:

The Medical Staff Executive Committee will appoint a Nominating Committee at least four (4) months in advance of the election of officers. Members of the Nominating Committee must meet the qualifications set forth in Section 3.B of these Bylaws. The President of the Medical Staff and the CMO will be *ex officio* members, without vote, on the Nominating Committee.

3.D.2. Election:

(a) Only Active Medical Staff Members are eligible to vote.

(b) Elections for officers will take place in October, as scheduled by the Medical Staff Executive Committee.

(c) The candidates receiving a majority of the votes cast will be elected, subject to Board confirmation.

(d) If no candidate receives a simple majority vote on the first ballot, the candidate who receives the smallest number of votes shall be eliminated from the succeeding ballot, and additional successive ballots shall be taken until a candidate receives such a majority.

3.E. TERM OF OFFICE, VACANCIES AND REMOVAL

3.E.1. Term of Office:

(a) Officers will assume office on the first day of the Medical Staff year.

(b) Officers will serve an initial one-year term and may be reelected for additional one-year terms.

3.E.2. Vacancies:

(a) If there is a vacancy in the office of President of the Medical Staff, the Vice President will serve until the end of the unexpired term of the President of the Medical Staff.

(b) If there is a vacancy in the office of Vice President or Secretary-Treasurer, the Medical Staff Executive Committee will appoint an individual, who satisfies the qualifications set forth in Section 3.B of these Bylaws, to the office until a special election can be held. The appointment will be effective upon approval by the Board.

(c) If there is a vacancy in the position of an at-large member of the Medical Staff Executive Committee, the Medical Staff Executive Committee will appoint an individual, who satisfies the qualifications set forth in Section 3.B of these Bylaws, to the position until a special election can be held. The appointment will be effective upon approval by the Board.

3.E.3. Removal:

(a) Removal of an elected officer of the Medical Staff Executive Committee may be effectuated by a 66% vote of the voting members of the Medical Staff returning their ballots, or a 66% vote of the voting members of the Medical Staff Executive Committee, or by the Board for:

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

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

(3) conduct detrimental to the interests of the Medical Staff or the Hospital;

(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 Section 3.B of these Bylaws.

(b) Prior to scheduling a meeting to consider removal, a representative from the Medical Staff, Medical Staff Executive Committee or the 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 Medical Staff Executive Committee, the Active Staff, or the Board, as applicable, prior to a vote on removal.

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

ARTICLE 4

CLINICAL DEPARTMENTS

4.A. ORGANIZATION

4.A.1. Organization of Departments:

The Medical Staff may be organized by the clinical departments and service lines as listed in the Medical Staff Organization Manual.

4.A.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.

4.A.3. Functions of 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 in these Bylaws and related documents.

4.B. DEPARTMENT CHAIRS AND VICE CHAIRS

4.B.1. Qualifications:

Each chair (and vice chair) will:

(a) be an Active Staff Member;

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

(c) satisfy the eligibility criteria in Section 3.B.

4.B.2. Selection and Term of Chairs:

(a) Except as otherwise provided by contract, when there is a vacancy in a chairperson or vice chair position, or a new department is created, the department will elect a new chair or vice-chair at its next regularly-scheduled meeting. The election of a chairperson by the department will be forwarded to the Board for final action.

(b) Elected chairs will serve a term of one year and may be elected for additional one-year terms.

4.B.3. Removal of Chairs and Vice Chairs:

(a) Removal of a chair or vice chair may be effectuated by a 66% vote of the Medical Staff Executive Committee, the department, or by the Board for:

(1) failure to comply with the Bylaws or applicable policies, or rules and regulations;

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

(3) conduct detrimental to the interests of the Medical Staff or the Hospital;

(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 Section 3.B of these Bylaws.

(b) Prior to scheduling a meeting to consider removal, a representative from the department, Medical Staff 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 Staff Executive Committee, or the Board, as applicable, prior to a vote on removal.

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

4.B.4. Duties of Chairs:

Each chair assists and oversees the following functions, either individually or in collaboration with Hospital personnel:

(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;

(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 inter-department and intra-department 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 individuals 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) may assist with the orientation and continuing education of Members in the department;

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

(p) performing functions authorized in the Credentials Policy, including collegial intervention efforts.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. GENERAL

5.A.1. Appointment:

(a) This Article and the Medical Staff Organization Manual outline the committees of the Medical Staff that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

(b) Except as otherwise provided by these Bylaws or the Medical Staff Organization Manual, the President of the Medical Staff will appoint the members and the chair of each Medical Staff committee, in consultation with the Chief Executive Officer. Committee chairs must satisfy the criteria in Section 3.B of these Bylaws. The President of the Medical Staff will also recommend Medical Staff representatives to Hospital committees.

(c) The Chief Executive Officer will make appointments of administrative staff to Medical Staff committees. Administrative staff will serve on Medical Staff committees without the right to vote.

(d) Chairs and members of standing committees will be appointed for an initial term of one year, but may be reappointed for additional terms.

(e) Chairs and members of standing committees may be removed and vacancies filled at the discretion of the person who initially appointed them.

(f) The President of the Medical Staff will be an *ex officio* member, with vote, on all Medical Staff committees.

(g) The Chief Executive Officer will be an *ex officio* member, without vote, on all Medical Staff committees.

5.A.2. Meetings, Reports and Recommendations:

Except as otherwise provided, committees will meet, as necessary, to accomplish their functions, and will maintain a permanent record of their findings, proceedings, and actions. Committees will make timely written reports to the Medical Staff Executive Committee.

5.B. MEDICAL STAFF EXECUTIVE COMMITTEE

5.B.1. Composition:

(a) The Medical Staff Executive Committee will include:

(1) President, Vice President, and Secretary/Treasurer;
(2) Each clinical department chair; and
(3) Chair of Credentials Committee.

(b) The Medical Staff Executive Committee may include a Member at Large, with vote, if a member of the Medical Staff is available and willing to serve.

(c) The President of the Medical Staff will serve as Chair of the Medical Staff Executive Committee, with vote.

(d) The Chair of the Board, Chief Medical Officer, and Chief Executive Officer may attend meetings of the Medical Staff Executive Committee, *ex officio*, without vote.

(e) Other individuals may be invited to Medical Staff Executive Committee meetings as guests, without vote.

5.B.2. Duties:

The Medical Staff Executive Committee is delegated the primary authority over activities related to the Medical Staff and to performance improvement activities. This authority may be removed or modified by amending these Bylaws and related policies. The Medical Staff 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 Staff 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; and

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

(c) consulting with Management 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 and health information management;

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

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

(i) recommending departments, if any, to be provided by telemedicine;

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

(k) performing any other functions as are assigned to it by these Bylaws, the Credentials Policy, Organizational Manual, or other applicable policies.

5.B.3. Meetings:

The Medical Staff Executive Committee will meet monthly, at least ten (10) times per year, and as needed, to fulfill its responsibilities and maintain a permanent record of its proceedings and actions.

5.C. PERFORMANCE IMPROVEMENT FUNCTIONS

(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 Hospital's accrediting body and Centers for Medicare & Medicaid Services 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) appropriateness of clinical practice patterns;

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

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

(j) the use of developed criteria for autopsies;

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

(l) healthcare associated infections;

(m) unnecessary procedures or treatment;

(n) appropriate resource utilization;

(o) education of patients and families;

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

(q) accurate, timely, and legible completion of patients' medical records;

(r) the required content and quality of history and physical examinations, as well as the time frames required for completion, which are set forth in Article 9 of these Bylaws;

(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 the committees that carry out monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Medical Staff Organization Manual.

5.D. CREATION OF STANDING COMMITTEES AND SPECIAL TASK FORCES

(1) In accordance with the amendment provisions in the Medical Staff Organization Manual, the Medical Staff Executive Committee may, by resolution and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. The Medical Staff Executive Committee may also dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.

(2) Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special task force will be performed by the Medical Staff Executive Committee.

(3) Special task forces will be created and their members and chairs will be appointed by the President of the Medical Staff and the Medical Staff Executive Committee. Such task forces will confine their activities to the purpose for which they were appointed and will report to the Medical Staff Executive Committee.

ARTICLE 6

MEETINGS

6.A. GENERAL

6.A.1. Meetings:

(a) The Medical Staff year is January 1 – December 31.

(b) Except as provided in these Bylaws or the Medical Staff Organization Manual, each department and Medical Staff committee will meet as often as needed to perform their designated functions.

6.A.2. Regular Meetings:

(a) The President of the Medical Staff, the chair of each department, and the chair of each committee will schedule regular meetings for the year.

(b) The Medical Staff will hold meetings quarterly. The annual meeting of the Medical Staff will be held in January of each year.

6.A.3. Special Meetings:

(a) A special meeting of the Medical Staff may be called by the President of the Medical Staff, a majority of the Medical Staff Executive Committee, or by a petition signed by at least 25% of the voting members of the Medical Staff.

(b) A special meeting of any department or committee may be called by the President of the Medical Staff, the relevant department or committee chair or by a petition signed by at least 25% of the voting members of the department or committee, but in no event fewer than two members.

(c) No business will be transacted at any special meeting except that stated in the meeting notice.

6.B. PROVISIONS COMMON TO ALL MEETINGS

6.B.1. Prerogatives of the Presiding Officer:

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

6.B.2. Notice:

(a) Medical Staff Members will be provided with notice of regular meetings of the Medical Staff and regular meetings of departments and committees. Notice will be provided via regular U.S. mail, e-mail, Hospital mail or by posting in a designated location at least 14 days in advance of the meeting.

(b) When a special meeting of the Medical Staff, department, or committee is called, the notice period will be 48 hours. Posting may not be the sole mechanism for providing notice.

(c) Notices will state the date, time, and place of the meetings.

(d) The attendance of any individual at any meeting will constitute a waiver of that individual's notice of the meeting.

6.B.3. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, department, or committee, those voting members present will constitute a quorum. Exceptions to this general rule are as follows:

(1) for meetings of the Medical Staff Executive Committee and the Credentials Committee, the presence of at least 50% of the voting committee members will constitute a quorum; and

(2) for any amendments to these Medical Staff Bylaws, at least 50% of the voting staff will constitute a quorum.

(b) Once a quorum is established, the business of the meeting may continue and actions taken will be binding.

(c) Recommendations and actions taken by the Medical Staff, department, and committees will be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority of the voting members. In the event that a recommendation or action before the Medical Staff Executive Committee results in a tie vote, such item shall be referred to the full medical staff for decision.

(d) As an alternative to a formal meeting, the voting members of the Medical Staff, a department, or committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the Presiding Officer by the method designated in the notice. Except for amendments to these Bylaws and actions by the Medical Staff Executive Committee and the Credentials Committee (as noted in (a)), a quorum for purposes of these votes will be the number of responses returned to the Presiding Officer by the date indicated. The question raised will be determined in the affirmative and will be binding if a majority of the responses returned has so indicated.

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

(f) There shall be no proxy voting.

6.B.4. Minutes:

(a) Minutes of Medical Staff, department, and committee meetings will be prepared and signed by the Presiding Officer.

(b) Minutes will include a record of the attendance of members and the recommendations made.

(c) Minutes of meetings of the Medical Staff, departments, and committees will be forwarded to the Medical Staff Executive Committee and a copy will be provided to the Chief Executive Officer.

(d) The Board will be kept apprised of and act on the recommendations of the Medical Staff.

(e) A permanent file of the minutes of meetings will be maintained by the Hospital.

6.B.5. Confidentiality:

(a) Medical Staff business conducted by committees and departments is considered confidential and proprietary and should be treated as such.

(b) Members of the Medical Staff who have access to, or are the subject of, credentialing or peer review information must agree to maintain the confidentiality of the information.

(c) Credentialing and peer review documents, and information contained in these documents, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy.

(d) A breach of confidentiality may result in the imposition of disciplinary action.

6.C. ATTENDANCE

6.C.1. Regular and Special Meetings:

(a) Members of the Medical Staff are encouraged to attend Medical Staff and applicable department and committee meetings. Attendance for Medical Staff meetings may be in person, telephonic or electronic conferencing.

(b) Members of the Medical Staff Executive Committee and the Credentials Committee are required to attend at least 50% of the regular meetings. Failure to attend the required number of meetings may result in replacement of the member.

ARTICLE 7

BASIC STEPS

The details associated with the following Basic Steps are contained in the Credentials Policy in a more expansive form.

7.A. QUALIFICATIONS FOR APPOINTMENT AND REAPPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or the Allied Health Staff, or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges and scope of practice requested as set forth in the Credentials Policy.

7.B. PROCESS FOR CREDENTIALING AND PRIVILEGING

(1) Complete applications for appointment and privileges will be transmitted to the applicable department chairperson, who will review the individual's education, training, and experience and prepare a written report stating whether the individual meets all qualifications. This report will be forwarded to the Credentials Committee.

(2) The Credentials Committee will review the chairperson's report, the application, and supporting materials and make a recommendation. The recommendation of the Credentials Committee will be forwarded, along with the department chairperson's report, to the Medical Staff Executive Committee for review and recommendation.

(3) The Medical Staff Executive Committee may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the Medical Staff Executive Committee is to grant appointment or reappointment and privileges, it will be forwarded to the Board for final action. If the recommendation of the Medical Staff Executive Committee is unfavorable, the individual will be notified by the Chief Executive Officer of the right to request a hearing.

7.C. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and clinical privileges may be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) timely complete medical records;

(ii) satisfy threshold eligibility criteria;

(iii) complete and comply with educational or training requirements;

(iv) provide requested information;

(v) attend a required meeting to discuss issues or concerns; or

(vi) comply with a requested fitness or practice evaluation;

(b) is arrested, charged, indicted, convicted, or pleads guilty or no contest pertaining to any felony, or to any misdemeanor including, but not limited to, (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) violence; (v) sexual misconduct; (vi) moral turpitude; or (vii) child or elder abuse;

(c) makes a misstatement or omission on an application form;

(d) in the case of an allied health professional, fails, for any reason, to maintain an appropriate supervision/collaborative relationship with a Supervising/Collaborating Physician as defined in the Credentials Policy; or

(e) remains absent on leave for longer than one year, unless an extension is granted by the Chief Executive Officer, in consultation with the President of the Medical Staff.

(2) Automatic relinquishment will take effect immediately and will continue until the matter is resolved, if applicable.

(3) Any individual who is the subject of an automatic relinquishment of appointment and/or clinical privileges may request a hearing with the Medical Staff Executive Committee within three days of the notice of the automatic relinquishment.

7.D. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Chief Executive Officer, the President of the Medical Staff, the chairperson of the relevant clinical department, the Medical Staff Executive Committee, or the Board chairperson is authorized to suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the Chief Executive Officer or the Medical Staff Executive Committee.

(3) The individual will 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, and may request a hearing with the Medical Staff Executive Committee within three days of the imposition of the precautionary suspension or restriction. The hearing shall be held within 15 days of the imposition of the suspension or restriction (unless the individual and the Medical Staff Executive Committee agree upon a different time frame/schedule).

7.E. INDICATIONS AND PROCESS FOR PROFESSIONAL REVIEW ACTIONS

Following an investigation, the Medical Staff Executive Committee may recommend suspension or revocation of appointment or clinical privileges, based on concerns about (a) clinical competence or practice; (b) the safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, policies, rules and regulations of the Hospital or the Medical Staff; or (d) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff.

7.F. HEARING AND APPEAL PROCESS

(1) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members or there will be a Hearing Officer.

(3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

(4) A stenographic reporter will be present to make a record of the hearing.

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness; (d) to have representation by counsel who may be present but may not call, examine, and cross-examine witnesses or present the case; (e) to submit a written statement at the close of the hearing; and (f) to submit proposed findings, conclusions and recommendations to the Hearing Panel (or Hearing Officer).

(6) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

(7) The Hearing Panel (or Hearing Officer) may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

(8) The affected individual and the Medical Staff Executive Committee may request an appeal of the recommendations of the Hearing Panel (or Hearing Officer) to the Board.

ARTICLE 8

AMENDMENTS

8.A. MEDICAL STAFF BYLAWS

(1) Amendments to these Bylaws may be proposed by a petition signed by 50% percent of the voting Members of the Medical Staff, by the Bylaws Committee, or by the Medical Staff Executive Committee.

(2) Proposed amendments must be reviewed by the Medical Staff Executive Committee prior to a vote by the Medical Staff. The Medical Staff Executive Committee will provide notice of proposed amendments, including amendments proposed by the voting members of the Medical Staff as set forth above, to the voting staff. The Medical Staff 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 meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(4) In the alternative, the Medical Staff Executive Committee may present any proposed amendments to the voting staff by written or electronic ballot, returned to the Hospital by the date indicated by the Medical Staff Executive Committee. Along with the proposed amendments, the Medical Staff Executive Committee may, in its discretion, provide a written report on them, either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast.

(5) The Medical Staff Executive Committee will 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) Amendments will 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 Staff Executive Committee or the Medical Staff, the Medical Staff Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference will 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 Chief Executive Officer within two weeks after receipt of a request.

(8) Neither the Medical Staff Executive Committee, the Medical Staff, the Bylaws Committee, nor the Board can unilaterally amend these Bylaws.

8.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there will be policies, procedures, and rules and regulations that are applicable to Members and other individuals who have been granted clinical privileges.

(2) An amendment to the Credentials Policy, the Medical Staff Organization Manual, or the Medical Staff Rules and Regulations may be made by a majority vote of the Members of the Medical Staff Executive Committee present and voting at any meeting of that committee where a quorum exists. Notice of any proposed amendments to these documents will be provided to each voting member of the Medical Staff at least 14 days prior to the vote by the Medical Staff Executive Committee. Any voting member may submit written comments on the amendments to the Medical Staff Executive Committee.

(3) Amendments to the Credentials Policy, or any other Medical Staff policy, the Medical Staff Organization Manual, or the Medical Staff Rules and Regulations may also be proposed by a petition signed by at least 25% of the voting members of the Medical Staff. Notice of any such proposed amendment to these documents will be provided to the Medical Staff Executive Committee at least 30 days prior to being voted on by the Medical Staff. Any such proposed amendments will be reviewed by the Medical Staff Executive Committee, which may comment on the amendment before it is forwarded to the Medical Staff for vote.

(4) Other policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Staff Executive Committee. No prior notice is required.

(5) The Medical Staff Executive Committee and the Board will have the power to provisionally adopt urgent amendments to the 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 provisionally adopted amendments will be provided to each Member of the Medical Staff as soon as possible. The Medical Staff will have 30 days to review and provide comments on the provisional amendments to the Medical Staff Executive Committee. If there is no conflict between the Medical Staff and the Medical Staff Executive Committee, the provisional amendments will stand. If there is conflict over the provisional amendments, the process for resolving conflicts set forth below will be implemented.

(6) Adoption of and changes to the Credentials Policy, Medical Staff Organization Manual, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

(7) Amendments to Medical Staff policies are to be distributed or otherwise made available to Medical Staff Members and those otherwise holding clinical privileges, in a timely and effective manner.

8.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the Medical Staff Executive Committee, supported by a petition signed by 25% of the voting staff, with regard to:

(a) a new Medical Staff Rule and Regulation proposed by the Medical Staff Executive Committee or an amendment to an existing Rule and Regulation; or

(b) a new Medical Staff policy proposed by the Medical Staff Executive Committee or an amendment to an existing policy,

a special meeting of the Medical Staff to discuss the conflict will be called. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the Rules and Regulations or policy at issue.

(2) If the differences cannot be resolved at the meeting, the Medical Staff Executive Committee will 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 actions concerning individual Members of the Medical Staff.

(4) Nothing in this section is intended to prevent individual Medical Staff Members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board. Communication from Medical Staff Members to the Board will be directed through the Chief Executive Officer, who will forward the request for communication to the Board Chairperson. The Chief Executive Officer will also provide notification to the Medical Staff Executive Committee by informing the President of the Medical Staff of such exchanges. The Board Chair will determine the manner and method of the Board's response to the Medical Staff Member(s).

ARTICLE 9

HISTORY AND PHYSICAL

(a) General Documentation Requirements

(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.

(2) 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:

- cardiovascular;
- respiratory;
- gastrointestinal;
- neuromusculoskeletal; and
- 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.

(b) H&Ps Performed Prior to Admission

(1) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.

(2) If a medical history and physical examination has been completed 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. However, in these circumstances, the patient must also be evaluated by the admitting physician or surgeon performing the procedure within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record. For a surgical patient, the surgeon will perform the updated history and physical.

(3) The update of the history and physical examination will be based upon an examination of the patient and must (i) reflect any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition.

(4) In the case of readmission of a patient, previous records will be made available by the Hospital for review and use by the attending physician.

(c) Cancellations, Delays, and Emergency Situations

(1) When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, procedures performed in the operating suites, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until an appropriate history and physical examination is recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.

(2) In an emergency situation, when there is no time to record either a complete or a Short Stay history and physical, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress

note will document, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a complete history and physical examination.

(d) Short Stay Documentation Requirements

A Short Stay History and Physical Form, approved by the Medical Staff Executive Committee, may be utilized for (i) ambulatory or same day procedures, or (ii) short stay observations which do not meet inpatient criteria. These forms will document the chief complaint or reason for the procedure, the relevant history of the present illness or injury, and the patient's current clinical condition/physical findings.

(e) Prenatal Records

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.

ARTICLE 10

ADOPTION

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter contained herein.

Originally adopted by the Medical Staff:	
Originally approved by the Board:	
Revisions adopted by the Medical Staff:	8/18/2025
Revisions approved by the Board:	08/28/2025