MEDICAL STAFF
BYLAWS

July 24, 2024

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PREAMBLE

These Bylaws provide a framework for governance of the Medical Staff at Clinton Memorial Hospital, a for profit hospital, to permit Medical Staff Appointees to discharge their responsibilities in matters involving the quality of medical care and to govern the orderly resolution of those purposes. These Bylaws provide structure for Medical Staff operations, and relations among Practitioners with the Hospital Administration and the Board of Trustees and with applicants for appointment to the Medical Staff and/or Privileges, all subject to the corporate authority of the Board of Trustees in those matters where the Board has ultimate legal responsibility.

WHEREAS, Clinton Memorial Hospital, hereinafter referred to as "Hospital", is operated by RCHP-Wilmington, LLC hereinafter referred to as "Corporation", a private corporation organized under the laws of the State of Ohio and is lawfully doing business in Ohio, and is not an agency or instrumentality of any state, county or federal government; and

WHEREAS, no person is entitled to Medical Staff membership and privileges at this Hospital solely by reason of education or licensure, or membership on the Medical Staff of another hospital; and

WHEREAS, the purpose of this Hospital is to serve as a general short-term, acute care hospital, providing patient care and education; and

WHEREAS, the Hospital must ensure that such services are delivered efficiently and with concern for keeping medical costs within reasonable bounds and meeting the evolving regulatory requirements applicable to functions within the Hospital; and

WHEREAS, the Medical Staff must cooperate with and is subject to the ultimate authority and direction of the Board of Trustees; and

WHEREAS, the cooperative efforts of the Medical Staff, management and the Board of Trustees are necessary to fulfill these goals.

NOW, THEREFORE, the practitioners practicing in Clinton Memorial Hospital hereby organize themselves into a Medical Staff conforming to these bylaws.

DEFINITIONS

1. "Active Staff" members shall be those physicians (D.O.s and M.D.s) licensed in the state of Ohio that have the privilege of admitting patients, holding office and voting.
2. "Advanced Practice Professional" or "APP" means an individual, other than a Practitioner, who is qualified to render direct or indirect medical or surgical care under the supervision of a, who has been afforded privileges within their scope of practice to provide such care in the hospital. Such APPs shall include, Certified Nurse Practitioner, Certified Nurse Midwife, Clinical Nurse Specialist, Certified Registered Nurse Anesthetists) without limitation, and other such professionals. The authority of an APP to provide specified patient care services is established by the Medical Staff based on the professional's qualifications. APPs permitted to practice without supervision may only do so if permitted by state law and are specifically credentialed to practice independently by the medical staff and Board.
3. "APP Staff" means the formal organization of APPs who are eligible to be granted clinical privileges pursuant to these Bylaws.
4. "Board of Trustees" or "Board" means the Board of Trustees of Clinton Memorial Hospital.
5. "Board Certification" shall mean certification in one of the Member Boards of the American Board of Medical Specialties (ABMS) or the Bureau of Osteopathic Specialists certifying boards of the American Osteopathic Association (AOA). The National Board of Physicians & Surgeons (NBPAS) may be used for recertification if initial certification was granted by one of the Member Boards of the ABMS or the Bureau of Osteopathic Specialists certifying boards of the AOA. For podiatrists, board certification shall mean certification of the American Board of Podiatric Surgery (ABPS). For dentists, board certification shall mean certification by the American Board of Oral/Maxillofacial Surgeons (ABOMS).
6. "Chief of Staff" means the member of the Active Medical Staff who is duly elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital or his/her designee.
7. "Clinical Privileges" means the Board's recognition of an individual's competence and qualifications to render specific diagnostic, therapeutic, medical, dental, podiatric, chiropractic or surgical services.
8. "Corporation" means RCHP-Wilmington, LLC.
9. "Data Bank" means the National Practitioner Data Bank, established pursuant to the Health Care Quality Improvement Act of 1986.
10. "Designee" means one selected by the CEO, Chief of Staff, or other officer to act on his/her behalf with regard to a particular responsibility or activity as permitted by these Bylaws.
11. "Ex-officio" means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

12. "Fair Hearing Plan" means the procedure adopted by the Medical Staff with the approval of the Board to provide for an evidentiary hearing and appeals procedure when a physician's or dentist's clinical privileges are adversely affected by a determination based on the physician's or dentist's professional conduct or competence.

13. "Hospital" means Clinton Memorial Hospital ~~and its hospital owned practices~~.

14. "Medical Executive Committee" or "MEC" means the Executive Committee of the Medical Staff.

15. "Medical Staff" or "Organized Medical Staff" means the formal organization of Practitioners who have been granted Medical Staff membership.

16. "Medical Staff Bylaws" means the "Bylaws" of the Medical Staff and the accompanying Rules & Regulations, Fair Hearing Plan, policies and such other rules and regulations as may be adopted by the Medical Staff and subject to approval of the Board.

17. "Medical Staff Year" means the period from January 1 through December 31.

18. "Member" means a Practitioner who has been granted Medical Staff membership and is eligible to be granted clinical privileges pursuant to these Bylaws.

19. "Physician" means a graduate of an approved medical or osteopathic school of medicine who is properly licensed in the State of Ohio to practice medicine.

20. "Practitioner" means a Physician, Dentist, or Podiatrist who has been granted clinical privileges and/or Medical Staff membership in the Hospital.

21. "Prerogative" means a participatory right granted, by of the Medical Staff and exercised subject to the conditions imposed in these Bylaws and in other Hospital and Medical Staff policies.

22. "Professional Performance Review Policy" means the policy and procedure adopted by the Medical Staff with the approval of the Board to provide evidence of objective monitoring of quality concerns for clinical management and evaluation of outcomes, provide oversight of the professional performance of all Practitioners with delineated clinical privileges, evaluate the competence of Practitioner performance, establish guidelines and triggers for referring cases identified or suspected as variations from quality indicators, and facilitate delivery of quality services that meet professionally recognized standards. This policy is incorporated into these Bylaws and is contained in Appendix "E" hereto.

23. "Provider" means physicians, dentists, podiatrists, and APPs with clinical privileges at the Hospital

24. "Chief Executive Officer" or "CEO" means the individual appointed by the Corporation to provide for the overall management of the Hospital or his/her designee.

25. "Special Notice" means written notification that is either sent by certified mail, return receipt requested, or personal delivery with signed receipt.

26. "Telemedicine" aka "Telehealth" means the use of electronic equipment or other communication technologies to provide or support clinical care at a distance.

Whenever the terms, "he," "him," "himself" or "his" are used in these Bylaws, they represent both the masculine and feminine gender, unless specifically stated otherwise.

Every reference to an officer (e.g., "CEO," "Chief of Staff," "Service Chief," etc.) in the Bylaws, shall mean the officer "or the officer's designee" and shall allow a designee to be substituted for the officer, unless otherwise provided.

OTHER

These Bylaws are not intended to and shall not create any contractual rights between the Hospital and any Practitioner. Any and all contracts of association or employment shall control contractual and financial relationships between the Hospital and such Practitioners.

ARTICLE I:

NAME

The Medical Staff shall be called Clinton Memorial Hospital Medical Staff.

ARTICLE II:

RESPONSIBILITIES

SECTION 2.1. RESPONSIBILITIES

2.1-1 The responsibilities of the Staff are:

a. To assist in the development, review and amendment of Bylaws, rules and regulations and other Medical Staff policies, and to enforce and comply with them once adopted by the Board.

b. To participate in the regular review, evaluation and monitoring of patient care rendered by all Practitioners and Advanced Practice Professionals to account to the Board of Trustees regarding same through regular reports and recommendations.

c. To participate in a program of continuing education, the majority of which is related to the Clinical Privileges granted.

d. To assist in identifying community health needs, setting appropriate institutional goals and implementing programs to meet these needs.

e. To recommend to the Board of Trustees, through the MEC, action with respect to appointments, reappointments, Medical Staff category and Department assignments, Clinical Privileges, and corrective action.

f. To initiate and make recommendations to the Board, through the MEC, regarding corrective action with respect to Practitioners and APPs when warranted.

g. Investigate any breach of ethics that is reported to it.

h. To participate in Hospital-wide performance improvement activities, including participating in the following activities:

1. education of patients and families;

2. coordination of care, treatment, and services with other Practitioners, APP's, and Hospital personnel, as relevant to the care, treatment, and services of an individual patient;

3. accurate, timely, and legible completion of patient's medical records;

4. review of findings of the assessment process that are relevant to an individual's performance and use of this information in the ongoing evaluations of a Practitioner's and APP's competence; and

5. communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Staff Appointees and the Board.

i. To provide a means through which the Medical Staff will participate in the Hospital's policy-making and planning process, including providing advice and input to the Hospital:

1. in the process of annually evaluating the Hospital's performance in relation to its mission, vision, and goals;

2. on the sources of clinical services to be provided at the Hospital by consultation, contractual arrangements, or other agreements;

3. regarding the Hospital's annual budget;

4. in the developing and implementing of plans for allowing efficient patient flow throughout the Hospital;

5. in the developing and implementing of written policies and procedures for donating and procuring organs and tissues;

6. in the developing and reviewing clinical practice guidelines; and

7. in the development of ongoing processes for the management of conflict between leadership groups within the Hospital.

j. To account for the oversight of care, treatment, and services provided by Appointees and Practitioners and APPs with Clinical Privileges by:

1. active involvement in the measurement, assessment, and improvement of the medical assessment and treatment of patients;

2. performance of credentials evaluations for appointment and reappointment to the Medical Staff and the granting of Clinical Privileges to be exercised based upon the verification and evaluation of credentials, character, and performance;

3. performance of utilization review, to assure appropriate allocation of the Hospital's resources to provide high-quality patient care in a cost effective manner;

4. timely performance of retrospective and concurrent review and evaluation of the quality and appropriateness of patient care as provided through participation in the Hospital's professional practice evaluation and quality improvement programs, including but not limited to focused professional practice evaluations (FPPEs) and ongoing professional practice evaluations (OPPEs).

5. implementing a process to identify and manage matters of individual Practitioner or APP's health that is within the purview of the Peer Support

Committee in accordance with the Medical Staff Disruptive Practitioner Policy.

k. To account to the Board for the quality and efficiency of patient care, treatment, and services rendered in the Hospital through regular reports and recommendations concerning the implementation, operation, and results of quality improvement activities as provided by the quality improvement plan and provide:

1. leadership in activities related to patient safety; and

2. oversight in the process of analyzing and improving patient satisfaction.

SECTION 2.2. PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENTS

Patient information will be collected, stored, and maintained so that privacy and confidentiality are preserved. The hospital and all health care providers will be part of an Organized Health Care Arrangement ("OHCA"), which is defined as a clinically integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. The OHCA allows the Hospital and the providers to share information for purposes of treatment, payment, and health care operations. Under the OHCA, at the time of admission, a patient will receive the Hospital's Noice of Privacy Practices, which will include information about the Organized Health Care Arrangement.

ARTICLE III:

COMPOSITION OF THE MEDICAL STAFF

SECTION 3.1. NATURE OF APPOINTMENT AND PRIVILEGES

Appointment and reappointment to the Medical Staff of Clinton Memorial Hospital and/or the granting/re-granting of Clinical Privileges is a privilege extended only to professionally competent Physicians, Dentists, Podiatrists, and Psychologists who meet the qualifications, standards and requirements set forth in these Medical Staff Bylaws and the Medical Staff Development Plan or such other criteria as the Board may from time to time establish, on an ongoing basis. Appointment and reappointment to the Staff shall confer on the Appointee only such Clinical Privileges and Prerogatives as have been duly granted by the Board.

SECTION 3.2. QUALIFICATIONS

3.2-1 Practitioners shall meet the following qualifications for Medical Staff appointment and/or Privileges unless otherwise provided in the Medical Staff Bylaws or Policies:

a. Practitioners shall be a graduate of an approved medical or osteopathic school of medicine or dental school, or college of podiatry, or hold a doctoral degree in psychology, and hold an unrestricted license to practice in the State of Ohio.

b. A Practitioner shall not have been terminated from the Medical Staff or received a final adverse initial appointment/Privileges decision from the Clinton Memorial Hospital Board of Trustees within the three (3) years preceding application. This restriction on qualification for application shall not apply to a Practitioner who has been subject to automatic termination of Staff appointment/Privileges pursuant to Section 7.5.

c. Practitioners shall possess a current Federal DEA certification/number if required by the Practitioner's Clinical Privileges or professional activity.

d. Only Practitioners who, on an ongoing basis, do the following shall be qualified for appointment to the Staff and/or Privileges:

1. Document their experience, education, background, training, ability, current competence, and ability to perform the Clinical Privileges requested, with sufficient adequacy to demonstrate to the Medical Staff and Board that they are capable of providing care at a generally professionally recognized level of quality and efficiency.

2. Are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions, work cooperatively with others, and participate in the discharge of Staff responsibilities.

3. Maintain and submit acceptable evidence of professional liability insurance coverage for Clinical Privileges requested in such amounts as are determined by the Board from time to time.

4. Not be and have never been excluded from Medicare, Medicaid or any other federal or state healthcare reimbursement program.

5. (i) Comply and have complied with federal, state and local requirements; and (ii) have not been subject to any significant liability claims which will adversely affect their services to the Hospital; and (iii) have not lost Medical Staff membership or privileges at any health care facility (e.g. hospitals, ASCs) based upon professional competence or conduct.

6. Not have ever been convicted of, or entered a guilty plea or no contest plea to any felony or serious offense related to controlled substances, illegal drugs, insurance or healthcare fraud or violence or abuse.

7. Be able to read and understand the English language and communicate effectively and legibly in English.

e. Any Practitioner who does not satisfy one (1) or more of the criteria set forth in Section 3.2(d)(1)-(7) above may request that it be waived. The Practitioner requesting the waiver bears the burden of demonstrating that the Practitioner meets the criteria or that other exceptional circumstances exist justifying a waiver. An application that fails to meet eligibility criterion will not be processed until the Board has determined that a waiver should be granted in accordance with this Section.

f. 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 Practitioner in question, input from the relevant Department Chair, and the best interest of the Hospital. The Credentials Committee may also consider the application and additional information that may be provided by the Applicant.

g. The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the reason(s) for the recommendation.

h. The Board may grant waivers in exceptional circumstances after considering the findings of the Credentials Committee and the Medical Executive Committee, the specific qualifications of the Practitioner in question, and the best interest of the Hospital. The granting of a waiver in a particular case is not intended to set a precedent for future applicants that may seek a waiver.

i. No Practitioner has a right to waiver or to a hearing if the Board denies the requested waiver. Rather the decision to grant a waiver rests solely with the Board. A

determination that a Practitioner is not entitled to a waiver is not a denial of privileges or appointment. Instead, the Practitioner is ineligible to request appointment or privileges for failure to meet the baseline qualifications. This ineligibility due to the failure to meet baseline qualification will cause the processing of the Practitioner's application to cease. Not processing the application further due to this ineligibility shall not entitle the applicant to the procedural rights provided in the Fair Hearing Plan. A denial of waiver 3.2 (d) (1) or (2) based on professional conduct or competence will entitle the applicant to a hearing as outlined in these bylaws and fair hearing plan.

j. All applicants who seek initial appointment to the Medical Staff after October 10, 2000, except for applicants for Physician Emeriti, must be certified by the appropriate specialty board of the American Board of Medical Specialties or the appropriate board of the American Osteopathic Association, American Dental Association Boards, American Podiatric Medical Association Boards, Psychology Boards, or National Board of Physician and Surgeons or equivalent for their specialty area of practice or must have successfully completed the necessary educational training required by the appropriate specialty board in which Clinical Privileges are sought and be working towards such board certification. Any such applicant who is not board certified at the time of initial appointment must obtain board certification within three (3) years of completion of the educational requirements in order to be eligible to apply for reappointment and Clinical Privileges; provided, however, the time within which board certification must be obtained may be extended by the relevant Department, to be set forth in the Criteria for Privilege Review, but such time period shall not exceed five (5) years after completion of the necessary educational training. All applicants who seek reappointment to the Active, Courtesy, or Consulting Staff categories of the Medical Staff, and who obtained initial appointment after October 10, 2000, must maintain certification by the appropriate specialty board of the American Board of Medical Specialties or the appropriate board of the American Osteopathic Association, American Dental Association Boards, American Podiatric Medical Association Boards, or Psychology Boards, in accordance with such board's recertification requirements for such applicant's specialty area of practice, in order to be eligible for reappointment to the Medical Staff.

k. Have successfully completed an approved residency program or the equivalent where applicable.

l. Have skills and training to fulfill a patient care need existing within the Hospital, and be able to adequately provide those services with the facilities and support services available at the Hospital.

m. Practice in such a manner as not to interfere with orderly and efficient rendering of services by the Hospital or by other practitioners within the Hospital.

3.2-2 Practitioners applying for Medical Staff appointment without Privileges shall satisfy such qualifications as set forth in the applicable appointment category and as otherwise recommended by the Medical Executive Committee and approved by the Board.

SECTION 3.3. OTHER AFFILIATIONS

No Practitioner is entitled to appointment on the Staff or APP Staff or to the exercise of particular Clinical Privileges solely because he or she (a) is licensed to practice in Ohio or in any other state, (b) is a member of any professional organization, (c) is certified by any clinical board, (d) presently holds or formerly held staff appointment or privileges at this Hospital or another health care facility, or in another practice setting, (e) is associated or affiliated with any group practice, or, (f) is employed by or contracts with the Hospital.

SECTION 3.4. NONDISCRIMINATION

Staff appointment and/or Clinical Privileges shall not be determined on the basis of race, color, creed, religion, national origin, gender, sexual orientation, or age.

SECTION 3.5. PRACTITIONER CONTRACTS

3.5-1 Credentialing Process:

No Medical Staff appointment or Clinical Privileges shall be granted as part of a contract or employment agreement. Practitioners employed by or under contract with the Hospital desiring Medical Staff appointment or Clinical Privileges must apply for Medical Staff appointment or Clinical Privileges through the normal credentialing process described in Article V.

3.5-2 Termination of Appointment:

Staff appointment and Privileges shall not terminate for those Practitioners who have been engaged by the Hospital on a contractual or employment agreement basis solely due to termination of the contract or employment unless the contract or employment agreement expressly provides for such automatic termination.

Unless otherwise provided in the contract for services, expiration or termination of any exclusive contract for services pursuant to this Section 6.6 or expiration or termination of any provider's employment with the contracting entity, shall automatically result in concurrent termination of Medical Staff or APP Staff membership and clinical privileges. The Fair Hearing Plan does not apply in this case, nor do Sections 5.5(b) or 5.5(c) for APPs.

SECTION 3.6. INDIVIDUAL RESPONSIBILITIES

3.6-1 Practitioners shall, unless otherwise provided in the Medical Staff Bylaws, Policies, or Rules & Regulations:

a. Be reasonably accessible for the performance of professional and Staff duties and obligations at the Hospital.

b. Provide patients with care at a professionally recognized level of quality and continuity; and, during periods of unavailability designate an alternate qualified practitioner with appropriate Privileges to provide the same care, who consents to serve as such alternate.

c. Abide by the Medical Staff Bylaws, Rules and Regulations, the Hospital's Code of Regulations and by all other standards, policies and rules of the Hospital.

d. Discharge such Staff, Committee and Hospital functions for which he is responsible by appointment, election or otherwise.

e. Prepare and complete in accordance with Medical Staff Rules and Regulations the medical records and other required documentation for all patients the Practitioner admits or treats in the Hospital.

f. Notify the CEO and Chief of Staff in writing within five (5) working days of any of the following events:

1. Voluntary or involuntary revocation or suspension of his professional license by any state.

2. Voluntary or involuntary revocation or temporary or permanent suspension of staff appointment or privileges or restrictive conditions placed upon him or her (other than for medical record delinquency) by any other hospital or other health care institution.

3. The voluntary or involuntary withdrawal of clinical privileges or the voluntary or involuntary reduction in staff status, and the reasons for said withdrawal or reduction, at any other hospital or other health care institution.

4. Commencement of a formal investigation, or the filing of charges, by the Department of Health and Human Services, any law enforcement agency or health regulatory agency of the United States or the State of Ohio or any professional association and outcomes of same, except traffic tickets and other minor actions having no bearing whatsoever on the ability to practice medicine. Convictions relating to substance abuse, theft, violent behavior, and moral turpitude shall be reported to the CEO.

5. Filing of any suit against him or her relating to the practice of medicine, dentistry, podiatry, or psychology and outcome of same, whether by settlement, verdict or otherwise.

6. Adverse status change as a provider in the Medicare or Medicaid programs or of any sanctions or penalties being placed upon him or her by the Centers for Medicare and Medicaid Services (CMS) or any other federal or state agency as a condition for continued participation in the Medicare Program or adverse finding against the Practitioner by a Medicare Quality Improvement Organization (QIO).

7. If the Practitioner at any time, even temporarily, fails to meet the qualifications listed in Section 3.2.

8. He/She is currently either voluntarily or involuntarily participating in any rehabilitation or impairment program, or has ceased participation in such a program without successful completion.

Failure to provide any such notice, as required above, may result in immediate loss of Medical Staff membership and clinical privileges, without right of fair hearing procedures

g. Seek consultations whenever required or medically prudent.

h. Participate in continuing education programs as required or requested and provide documentation to the Hospital if requested.

i. Adhere to the ethical standards of his or her profession.

j. Pay Medical Staff Dues and assessments as determined by the Staff and approved by the Board, however, Medical Staff dues may be waived or reduced for good cause as determined by the Medical Executive Committee and approved by the Board.

k. Cooperate with other members of the Medical Staff, APPs, management, the Board of Trustees and employees of the Hospital.

l. Attest and demonstrate that he/she is able to competently exercise the privileges requested, with or without a reasonable accommodation, prior to initial exercise of privileges.

m. Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Hospital.

3.6-2 Practitioners applying for Medical Staff appointment without Privileges shall satisfy such responsibilities as set forth in the applicable appointment category and as otherwise recommended by the Medical Executive Committee and approved by the Board.

SECTION 3.7. NATURE AND DURATION OF APPOINTMENTS

3.7-1 Appointment and Reappointment:

a. Appointment

Each appointment to the Medical Staff shall be for a defined period up to a maximum of thirty-six (36) months as granted by the Board or as otherwise provided in the Medical Staff Bylaws or Policies.

b. Reappointment

Reappointment to the Staff shall be for a period of up to thirty-six (36) months.

SECTION 3.8. LEAVE OF ABSENCE

3.8-1 Leave Status:

A Staff Appointee may request in writing to the CEO and Chief of Staff a voluntary leave of absence from the Staff specifying the length of time for the leave. No leave shall exceed one (1) year or the last date of the Practitioner's current appointment/Privilege period whichever occurs first. A leave of absence request may be granted by the Board, subject to such conditions or limitations as the Board determines to be appropriate. During the period of a leave of absence, the Staff Appointee's Privileges and Prerogatives shall be held in abeyance. The Practitioner on leave shall not have the Privilege of admitting or otherwise treating patients in the Hospital during the period of leave. The Practitioner shall be excused from all Medical Staff, Department, and committee meetings and from paying Staff dues during the period of leave; however, the Medical Staff requirement to maintain professional liability insurance shall continue during leave as provided in Section 3.8-2.

3.8-2 Professional Liability Insurance:

A Practitioner on leave of absence must maintain professional liability insurance coverage for all periods during which the Practitioner has previously held Clinical Privileges at the Hospital (including activities prior to the leave). A Practitioner seeking reinstatement from leave will be required to provide proof of such insurance in addition to maintaining insurance on an on-going basis.

3.8-3 Leave Termination:

a. At least forty-five (45) days or at such other time as the Board requires or approves, prior to the termination of the leave of absence, the Appointee must request reinstatement of his appointment, privileges and prerogatives by submitting a written

notice to that effect to the Board and the CEO. When requested by the Board or CEO, the Staff appointee shall submit within ten (10) days of the request a written summary of his relevant activities during the leave of absence.

b. All Practitioners requesting reinstatement must provide proof of satisfying the requirement of Section 3.8-2 by showing maintenance of the Practitioner's insurance coverage during the leave or that the Practitioner otherwise has coverage for all periods during which the Practitioner has previously held Clinical Privileges at the Hospital (including activities prior to the leave), such as by purchasing tail coverage covering such periods.

c. Practitioners requesting reinstatement shall be required to provide any additional information deemed necessary by the MEC or Board to evaluate the reinstatement.

d. The Credentials Committee shall make a recommendation to the Medical Executive Committee and the Board concerning reinstatement of the Practitioner's appointment and Privileges. Credentials Committee review of any request for reinstatement is mandatory. Upon Credentials Committee recommendation, the MEC and Board shall review and act on such application for reinstatement in the manner as described in these Bylaws for reappointment/re-grant of Privileges. If an Appointee fails to timely request reinstatement upon termination of a leave of absence, the MEC shall make a recommendation to the Board as to how the failure to request reinstatement should be construed. If such failure is determined to be a voluntary resignation, it shall not give rise to the procedural rights set forth in Article VIII of these Bylaws.

ARTICLE IV:

CATEGORIES OF THE STAFF

SECTION 4.1. CATEGORIES

The Staff shall be divided as follows: Active, Courtesy, Consulting, Physicians Emeriti, Active Without Privileges, and Telemedicine. The general responsibilities of members of all categories of Staff Appointees are found above in Section 3.6. To the extent the responsibilities of the categories differ, these specific responsibilities are provided below.

SECTION 4.2. ACTIVE STAFF

4.2-1 Qualifications:

The Active Staff shall consist of Practitioners who:

a. Satisfy the qualifications for Staff appointment set forth in the Bylaws, including but not limited to the qualifications set forth in Section 3.2;

b. Have an office and/or residence located within 30 miles of the Hospital in order to be continuously available for provision of care to his/her patients, as determined by the Board; and

c. Admit, attend, or are involved in the treatment of at least twelve (12) patients per year at the Hospital. For purposes of determining whether a practitioner is "involved" in the care of the requisite number of patients, a patient encounter or contact shall be deemed to include any of the following: admission; consultation with active participation in the patient's care; provision of direct patient care or intervention in the hospital setting; performance of any outpatient or inpatient surgical or diagnostic procedure; interpretation of any inpatient or outpatient diagnostic procedure or test; or admission or referral of a patient for inpatient care by a Hospitalist or other practitioner. When a patient has more than one procedure or diagnostic test performed or interpreted by the same practitioner during a single hospital stay, the multiple tests for that patient shall count as one patient contact.

4.2-2 Prerogatives:

An Active Staff Appointee may exercise the following Prerogatives:

a. Admit or render care to patients in the Hospital in accordance with the Clinical Privileges granted to him or her pursuant to these Bylaws.

b. Vote on all matters presented at general and special Staff meetings and committees of which he or she is a member; hold a Medical Staff Officer position if he or she satisfies the eligibility requirements for such office set forth in Article IX; and serve

as Medical Staff committee chair after he or she has been an Active Staff Appointee for two (2) years.

4.2-3 Responsibilities:

Each Active Staff Appointee shall:

a. Assume and retain responsibility, within his or her area of professional competence, for the daily care and supervision of each patient in the Hospital for whom he or she is providing attending services, or arrange for a qualified alternate to provide such care and supervision.

b. Comply with the Bylaws, Rules and Regulations, and applicable Medical Staff and Hospital policies and satisfy all other responsibilities set forth herein including but not limited to Staff and committee meeting attendance, as applicable, and quality improvement activities.

c. Provide inpatient care to patients admitted through the Emergency/Outpatient Services Departments, who have no local attending Practitioner, on a rotating basis per Emergency Department/Outpatient Services Protocols and Policies.

d. Provide follow-up care to patients treated and released from the Emergency Department who require such follow up care on an outpatient basis and who have no local attending Practitioner, on a rotating basis per Hospital Policy and Procedure for Emergency Outpatient Services Referral.

e. Provide on-call services on a rotating basis to the Emergency Department or other appropriate Hospital area for the evaluation and treatment of patients with potential emergency medical conditions per the Hospital's Emergency Medical Screening, Treatment, and Transfer Policy and Procedure and Emergency Department Protocols.

SECTION 4.3. CONSULTING STAFF

4.3-1 Qualifications:

The Consulting Staff shall consist of Practitioners who:

a. Satisfy the qualifications for Staff appointment set forth in the Bylaws, including but not limited to the qualifications set forth in Section 3.2;

b. Serve as a consultants to the Medical Staff and are willing to come to the Hospital on schedule or promptly respond when called to render clinical services within their area of competence, in accordance with the Clinical Privileges granted and subject to Section 4.3-1(c).

c. Do not admit, make assignments to observation beds (including obstetrics and obstetric triage), or perform invasive procedures within the surgical suites, including endoscopy suites and the interventional lab.

d. Are members of a staff category at another hospital, which is the equivalent of Clinton Memorial Hospital's Active Staff. Exceptions to this requirement may be recommended by the Credentials Committee for good cause.

4.3-2 Prerogatives:

A Consulting Staff Appointee:

a. May attend general Staff meetings, but may not vote and may not hold office.

b. May attend committee meetings, but has no specific Staff committee responsibilities.

4.3-3 Responsibilities:

A Consulting Appointee shall:

a. Comply with the Bylaws, Rules and Regulations, and applicable Medical Staff and Hospital policies and satisfy all other responsibilities set forth herein including but not limited to Staff and committee meeting attendance, as applicable and quality improvement activities.

SECTION 4.4. COURTESY STAFF

4.4-1 Qualifications:

The Courtesy Staff shall consist of Practitioners who:

a. Satisfy the basic qualifications for Staff appointment set forth herein;

b. Admit, attend, or are involved in the treatment of up to (11) patients per year at the Hospital.

4.4-2 Prerogatives:

A Courtesy Appointee may:

a. Admit or render care to patients in the Hospital in accordance with the Clinical Privileges granted to him or her pursuant to these Bylaws.

b. Serve as a member of committees, including as a voting member.

c. Attend meetings of the Staff. The Courtesy Staff Appointees shall not be eligible to vote (except when serving as a committee member); hold Staff office; or, serve as a committee chair.

4.4-3 Responsibilities:

A Courtesy Appointee shall:

a. Assume and retain responsibility, within his or her area of professional competence, for the daily care and supervision of each patient in the Hospital for whom he or she is providing attending services, or arrange for a qualified alternate to provide such care and supervision.

b. Comply with the Bylaws, Rules and Regulations, and applicable Medical Staff and Hospital policies and satisfy all other responsibilities set forth herein except attendance, provided, however, that Courtesy Staff Appointees who seek advancement to the Active Staff must satisfy all requirements of Active Staff set forth herein for at least one (1) year prior to the request for said advancement.

c. Provide on call services on a rotating basis to the Emergency Department or other appropriate Hospital area for the evaluation and treatment of patients with potential emergency medical conditions in accordance with the Hospital's Emergency Medical Screening, Treatment, and Transfer Policy and Procedure and Emergency Department Protocols.

d. Provide inpatient care to patients admitted through the Emergency/Outpatient Services Departments, who have no local attending Practitioner, on a rotating basis per Emergency Department/Outpatient Services Protocols.

e. Provide follow up care to patients treated and released from the Emergency Department who require such follow up care on an outpatient basis and who have no local attending Physician, on a rotating basis per Hospital Policy and Procedure for Emergency Outpatient Services Referral.

SECTION 4.5. PHYSICIANS EMERITI

4.5-1 Qualifications:

The Physicians Emeriti shall consist of Practitioners who:

a. By reason of their distinguished past service to Clinton Memorial Hospital and demonstrated excellence in the practice of medicine.

b. Do not admit, attend, or treat patients in the Hospital, but nevertheless wish to serve the Hospital on a continuing basis.

4.5-2 Prerogatives:

Appointees to the Physicians Emeriti Medical Staff category:

a. May attend Staff meetings.

b. May vote at Staff meetings.

c. May not hold Medical Staff office, but may serve on committees with or without a vote, and may serve as a committee chair.

d. Shall not be required to meet the qualifications set forth in Section 3.2 of these Bylaws.

e. Shall not be required to maintain any minimum insurance limits as otherwise required by these Bylaws or the Board.

f. Shall not be required to pay dues.

g. Shall be required to submit a request to retain Physician Emeriti membership at least every three (3) years; this process shall include a background check.

SECTION 4.6. ACTIVE WITHOUT PRIVILEGES STAFF

4.6-1 Qualifications:

The Active Without Privileges Medical Staff shall consist of members who meet the general qualifications set forth in Section 3.2 of these Medical Staff Bylaws and do not provide patient care in this Hospital.

4.6-2 Prerogatives:

Except as otherwise provided, the Active Without Privileges Medical Staff members shall be entitled to:

a. Refer patients to the Hospital for outpatient testing and/or procedures;

b. Refer patients to Active Staff members or Hospitalists for inpatient treatment. Active Without Privileges Staff may visit their referred patients in the Hospital, review patients' medical records and receive information concerning patients' medical condition and treatment, but may not participate in any inpatient treatment or make any entries in the medical record;

c. Attend meetings of the Medical Staff and the department of which he/she is a member, including open committee meetings, in a non-voting capacity;

d. Attend continuing medical education programs at the Hospital;

4.6-3 Limitations:

Members of the Active Without Privileges Medical Staff shall not be eligible to:

a. Vote, serve on committees, or hold offices in the Medical Staff;

b. Admit and/or treat patients;

c. Order tests on inpatients; or

d. Exercise any clinical privileges.

4.6-4 Appointment and Reappointment Requirements:

At initial appointment and each subsequent reappointment, information concerning the following shall be collected from the applicant and verified, if applicable:

a. Current licensure (in good standing) to practice medicine, osteopathy, podiatry, or dentistry in this State;

b. Adequate education and training;

c. Appropriate physical and mental health status;

d. Professional liability insurance that meets the requirements of these Bylaws;

e. DEA registration/controlled substance certificate;

f. Any charges, convictions or pleas. The practitioner shall notify the CEO and the Chief of Staff within seven (7) days of receiving notice of the initiation of any criminal charges, and shall acknowledge the Hospital's right to perform a background check at appointment, reappointment and any interim time when reasonable suspicion has been shown;

g. Any allegations of civil or criminal fraud pending against any applicant and any past allegations including their resolution and any investigations by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid; and

h. At least one (1) written recommendation from a current member in good standing of the Hospital Active Medical Staff.

No applicant shall be appointed or reappointed as a member of the Active Without Privileges Staff prior to completion of a query of the National Practitioner Data Bank.

4.6-5 Responsibilities:

Members of the Active Without Privileges Medical Staff will be expected to:

a. Adhere to the ethics of their respective professions;

b. Be able to work cooperatively with others;

c. Complete appointment and reappointment requirements;

d. Provide the following information when referring a patient for a diagnostic test or study: (a) physician name, State license number, office address and telephone number; and (b) a written order from the physician's office; and

e. Review all results of tests ordered and provide for such further outpatient medical care as the patient's condition may indicate. Since such patient care shall occur outside of the Hospital, neither the Medical Staff nor the Hospital shall be responsible for reviewing such care through the Performance/Quality Improvement Process or otherwise.

SECTION 4.7. TELEMEDICINE STAFF

4.7-1 Qualifications:

The Telemedicine Staff shall consist of Practitioners who:

a. satisfies the qualifications for Staff appointment set forth in the Bylaws, including but not limited to the qualifications set forth in Section 3.2;

b. are appropriately licensed, credentialed and privileged as stipulated in Section 4.7-2.

c. prescribes, renders a diagnosis or otherwise provides clinical treatment to Hospital patients only via an electronic communication link;

4.7-2 Credentialing Requirements

Members of the Telemedicine Staff shall be credentialed and privileged through one of the following mechanisms:

1) The Practitioner is credentialed and privileged by the Hospital in accordance with the applicable procedure set forth in Section 5.2.

2) The Practitioner is credentialed and privileged by the Hospital in accordance with the applicable procedure set forth in Section 5.2 of this Policy with the exception that the credentialing information and/or privileging decision from the distant site may be relied upon by the Medical Staff and Board in making its recommendations/decision provided that the Hospital has entered into a written agreement with the distant site and all of the following requirements are met:

(i) The distant site is a Medicare participating hospital or a facility that qualifies as a "distant site telemedicine entity." A "distant site telemedicine entity" is defined as an entity that (1) provides telemedicine services, (2) is not a Medicare participating hospital, and (3) provides contracted services in a manner that enables hospitals using its services to meet all applicable conditions of participation, particularly

those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of the hospital.

(a) When the distant site is a Medicare participating hospital, the written agreement shall specify that it is the responsibility of the distant site hospital to meet the credentialing requirements of 42 C.F.R. 482.12 (a)(l)-(a)(7), as that provision may be amended from time to time, with regard to the distant site hospital Practitioners providing telemedicine services.

(b) When the distant site is a "distant site telemedicine entity" the written agreement shall specify that the distant site telemedicine entity is a contractor of services to the Hospital and, as such, furnishes the contracted services in a manner that permits the Hospital to comply with all applicable conditions of participation for the contracted services including, but not limited to, 42 C.F.R. 482.12 (a)(l)-(a)(7), with regard to the distant site telemedicine entity Practitioners providing telemedicine services. The written agreement shall further specify that the distant site telemedicine entity's medical staff credentialing and privileging process and standards will, at minimum, meet the standards at 42 C.F.R. 482.12 (a)(l)-(a)(7) and at 42 C.F.R. 482.22 (a)(l)-(a)(2), as those provisions may be amended from time to time.

(ii) The individual distant site Practitioner is privileged at the distant site for those services to be provided to Hospital patients via telemedicine link and the Hospital is provided with a current list of his/her privileges at the distant site.

(iii) The individual distant site Practitioner holds an appropriate license or certificate issued by the State Medical Board of Ohio or other appropriate licensing entity.

(iv) The Hospital maintains documentation of its internal review of the performance of each distant site Practitioner and sends the distant site such performance information for use in the distant site's periodic appraisal of the distant site Practitioner. At a minimum, this information must include:

(a) All adverse events that result from the telemedicine services provided by the distant site Practitioner to Hospital patients; and,

(b) All complaints the Hospital receives about the distant site Practitioner.

4.7-3 Prerogatives:

A Telemedicine Staff Member must:

a. treat patients via electronic communication link;

b. exercise only such clinical privileges as are granted by the Board;

c. not admit patients to the Hospital;

d. attend general Staff meetings, but may not vote and may not hold office; and

e. attend committee meetings, but has no specific Staff committee responsibilities.

4.7-4 Responsibilities:

Members of the Telemedicine Staff will be expected to:

a. Adhere to the ethics of their respective professions;

b. Be able to work cooperatively with others;

c. Complete appointment and reappointment requirements; and

d. Comply with the applicable Bylaws, Rules and Regulations, and Medical Staff and Hospital policies and satisfy all other responsibilities set forth herein.

SECTION 4.8. LIMITATION OF PREROGATIVES

The Prerogatives set forth under each Staff category are general in nature and may be subject to limitations by special conditions to a Practitioner's appointment pursuant to these Bylaws, Rules and Regulations or by other policies of the Medical Staff, Credentials Committee or Board.

SECTION 4.9. WAIVER OF QUALIFICATIONS AND PROVISIONS

Any qualification or other provision in this Article or any other article of these Bylaws or the Medical Staff Policies or Rules & Regulations not required by law or governmental regulation may be waived at the discretion of the Board upon recommendation of the Medical Executive Committee.

ARTICLE V:

APPOINTMENT, REAPPOINTMENT AND PRIVILEGING

SECTION 5.1. GENERAL PROCEDURE

With the assistance of Medical Staff Services, the Credentials Committee and Medical Executive Committee shall investigate and consider each applicant for Medical Staff appointment or reappointment, each request for Clinical Privileges and each request for modification of Staff appointment status and/or Clinical Privileges and the Medical Executive Committee shall adopt and transmit recommendations thereof to the Board.

Individuals in administrative positions who desire Medical Staff membership or Clinical Privileges are subject to the same procedures as all other applicants for membership or Privileges.

SECTION 5.2. INITIAL APPOINTMENT, REAPPOINTMENT, AND PRIVILEGING PROCEDURE

5.2-1 Initial Appointment/Grant of Privileges

a. Application Form

Requests for Medical Staff applications are subject to the requirements of the Medical Staff Development Plan. Practitioners who are provided applications for appointment to the Medical Staff and/or Privileges shall submit such application within ninety (90) days after the date the application was initiated. Failure to return a complete application within ninety (90) days shall constitute a voluntary withdrawal of the application and the applicant shall have no rights to hearing or appellate review. The application shall be signed by the applicant and shall be submitted on a form developed by the Medical Staff and approved by the Board together with payment of a fee established by the Board. All applications for appointment, reappointment and Privileges shall be submitted to the Medical Staff Services designated central verification organization (CVO). At the time the applicant is forwarded an application for appointment to the Medical Staff and/or Privileges, he or she shall also receive, or be provided access to, a copy of the Medical Staff Bylaws, Policies, and Rules and Regulations and a description of the appointment and privileging mechanism. In addition, an applicant will be provided a setting specific core Privileges form appropriate to his or her specialty.

b. Content:

i. Information:

The application form shall include, but not necessarily be limited to:

(1) Provisions necessary to secure the following information to be used in the evaluation of the applicant: evidence the Practitioner requesting Medical Staff appointment and/or Privileges is the same individual in the credentialing documents; evidence of current licensure; current DEA registration/controlled substance certificate, if

applicable; relevant training and/or experience; current competence; adequate professional liability insurance; involvement in any suit against him or her relating to his or her practice and the outcome, whether by settlement, verdict, or otherwise; previously successful or currently pending challenges or limitations to any licensure or registration or the voluntary relinquishment of such licensure or registration; voluntary or involuntary termination or limitation of medical staff membership or temporary or permanent suspension, revocation, reduction, conditioned or limited medical staff appointment or clinical privileges at another hospital or any other health care institution; voluntary or involuntary withdrawal of privileges or limitation or reduction in medical staff status and the reasons for said withdrawal, limitation or reduction, at any other hospital or other health care institution; present and past status as a participant in the Medicare and Medicaid Programs; geographic location of the applicant; and peer recommendations who have directly worked with the practitioner/APP in a clinical setting in the previous 24 months .

(2) Attestation and confirmation that the applicant is able to safely and competently exercise the Privileges requested with or without a reasonable accommodation prior to initial exercise of Privileges.

(3) A consent form, in addition to the application, for processing a criminal background check.

(4) A questionnaire, in addition to the application, regarding conflicts of interest in accordance with the Hospital's conflicts of interest policy as such policy may be amended from time to time.

ii. Consents

The application form shall at a minimum include provisions, which signify the applicant's consent to the following:

(1) Inspection of records and documents pertinent to his or her licensure, training, experience, professional qualifications, competence, and ability to perform the Clinical Privileges requested with or without a reasonable accommodation, the satisfaction of the basic qualifications specified in the Medical Staff Bylaws for Medical Staff appointment and/or Privileges and any additional qualifications specified in the Bylaws for the particular Medical Staff category to which the applicant requests Medical Staff appointment.

(2) Release of information by his or her present and past professional liability insurance carrier(s).

(3) Appearance at an interview upon request of the Credentials Committee, the Medical Executive Committee or Board.

(4) Medical Staff Appointees and Hospital representatives consulting with employees, medical staff appointees, or representatives of other hospitals or any other health care institution with which the applicant is or has been associated and any other individuals who may have information bearing on the applicant's qualifications, competence and character.

iii. Confidentiality, Immunity, and Releases from Liability:

The application form shall include terms providing that the applicant agrees to abide by the confidentiality, immunity, and release provisions set forth in the Medical Staff Bylaws and further agrees to release the following from any liability, claim, demand, or expense whatsoever:

(1) The Medical Staff, Hospital, Board, and any of its authorized representatives including, but not limited to, any Practitioner consultant retained by the Hospital to assist in the credentialing process or any Practitioner who is otherwise consulted and responds in connection with the credentialing process or any future professional review action.

(2) All individuals, including those specified in the foregoing paragraph, and organizations that provide information to Medical Staff and Hospital representatives concerning the applicant's ability, professional ethics, character, ability to perform the Privileges requested, with or without a reasonable accommodation, and other qualifications.

iv. Acknowledgments:

The application form shall contain provisions, which signify that the applicant acknowledges the following:

(1) Receipt or access to the Medical Staff Bylaws, Policies, and Rules and Regulations.

(2) Receipt and understanding of the Medical Staff appointment and Clinical Privileges delineation and mechanism.

(3) Adverse Medical Executive Committee or Board actions that reduce, restrict, suspend, revoke, deny, or fail to renew Medical Staff appointment and/or Clinical Privileges on the basis of conduct or competency may result in National Practitioner Data Bank notification and/or reporting to state authorities.

v. Agreements:

The application form shall provide provisions pursuant to which the applicant agrees to/that:

(1) Abide by the Medical Staff Bylaws, Policies, and Rules and Regulations, the Hospital Code of Regulations, and by all other established standards, policies and rules of the Hospital.

(2) Satisfy his/her Medical Staff responsibilities including, but not limited to, providing for continuous care of his/her patients.

(3) When an adverse action or recommendation is made with respect to his/her Medical Staff appointment and/or Privileges, the applicant will exhaust the administrative remedies afforded by the Bylaws before resorting to formal legal action.

(4) Immediately inform the Hospital of any changes or developments affecting or changing the information provided in or with his/her application. The foregoing obligation shall be a continuing obligation of the applicant so long as he/she has Medical Staff appointment and/or Privileges at the Hospital.

vi. Falsification of Information or Incomplete Applications:

(1) The applicant shall acknowledge and attest that the application is correct and complete, and that any material misstatement or omission is grounds for denial or termination of appointment and Privileges.

(2) The applicant's falsification of information or failure to provide a complete application or any requested information or consents necessary for the completion and evaluation of the application shall be deemed to be a voluntary withdrawal of the application and the applicant shall have no rights to a hearing or appeal except for the limited purpose of resolving any dispute as to materiality of the misstatement or omission or actual facts.

vii. If the applicant has any concerns about the application, he or she should contact the Director of Credentialing in writing before submitting the application.

c. Process

i. Applicant’s Burden:

The applicant shall have the burden of submitting adequate and accurate information for a thorough evaluation of his or her experience, professional ethics, background, training, and demonstrated ability to exercise the Privileges requested with or without a reasonable accommodation; and, further, shall have the burden of resolving any questions about these or any of the qualifications specified in the Bylaws. The applicant shall file the completed application within 90 (ninety) days after the date the application is made available to him/her. Failure to complete the application within the designated time period will be considered a voluntary withdrawal of the application.

ii. Transmittal and Verification:

The applicant will complete his or her application via an online process through the hospital's contracted credentials verification organization (CVO). The CVO shall review the application for completeness, collect references, verify licensure and DEA status and other qualification evidence from the primary source, wherever feasible, including information gained from data banks as required by law. The CVO shall promptly notify the applicant of any difficulty in such collection and/or verification. Failure of the CVO to complete the application within 90 days will be considered a voluntary withdrawal of the application. The Medical Staff Office will perform a criminal background check, and after determining that the application is complete and all pertinent materials have been secured, shall compile the completed application form and all accompanying materials to the appropriate Department Director and the Director of Credentialing (as chair of the Credentials Committee) within ninety (90) days after receipt of a complete application. The Department Director shall review and comment to the Credentials Committee with respect to those Practitioners requesting Privileges within the Department. All applications will be considered in a good faith and timely manner using the guidelines set forth in these Bylaws. The guidelines are to assist persons engaged in the credentialing process in meeting their obligations and do not create any right of the applicant to have his/her application processed within such time period.

iii. Credentials Committee Action:

The Credentials Committee shall review any comments from the Department Director, and all information relevant to the qualifications of the applicant for the Medical Staff category and/or Clinical Privileges requested including information gained from data banks as required by law. The Credentials Committee may request additional information or conduct an interview of the applicant. If the applicant fails to provide the requested information within the designated time, the applicant shall be deemed to have voluntarily withdrawn his or her application and shall not be entitled to any hearing rights. The Credentials Committee review shall include a determination as to the adequacy of the Hospital's facilities and support services needed by the applicant for rendering care to his or her patients; and may include the need for additional Medical Staff Appointees with the skills and qualifications of the applicant. After such review and except as otherwise set forth in this paragraph, the Credentials Committee shall transmit to the Medical Executive Committee within sixty (60) days of the Director of Credentialing receipt of the completed application, a recommendation, as applicable, regarding Medical Staff appointment, Medical Staff category, the Clinical Privileges to be granted, and any special conditions to be attached to the appointment and/or Privileges. The reasons for any adverse recommendation shall be stated and supported by reference to the completed application and accompanying materials considered by the Credentials Committee, all of which shall be transmitted with the recommendation. The Credentials Committee may extend the foregoing sixty (60) day period for the purpose of obtaining additional information for a period not to exceed sixty (60) days, in which case, time for transmission to the Medical Executive Committee of the recommendation shall be increased by the period of extension.

iv. Medical Executive Committee Review

(1) At its next regular meeting after receipt of the recommendation(s) of the Credentials Committee, the MEC may:

a. Adopt the findings and recommendation of the Credentials Committee as its own.

b. Refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation. In such instance, the MEC shall set a time frame within which the Credentials Committee must respond.

c. Defer the application for further consideration. In such event, except for good cause, a recommendation must be made within thirty (30) days thereafter. The Chief of Staff shall advise the applicant in writing, by Special Notice, of any action to defer, including a request for the specific data/explanation or release/authorization, if any, required from the applicant and the time frame for response. Failure by the applicant, without good cause, to respond with the requested information within the specified time frame shall be deemed a voluntary withdrawal of the application without right to the procedural rights set forth in the Bylaws.

d. Make a recommendation different from that of the Credentials Committee stating the basis for its disagreement.

(2) If the recommendation of the MEC is to appoint/grant Privileges, the recommendation shall be forwarded to the Chief of Staff for presentation, together with all accompanying information, at the next regularly scheduled Board meeting for a final decision.

(3) If the recommendation of the MEC is adverse, the recommendation shall be forwarded to the Chief of Staff who shall promptly notify the applicant, by Special Notice, of the MEC's recommendation and of the applicant's procedural rights, if any, as provided in the Medical Staff Bylaws. The Chief of Staff shall then hold the application until after the applicant has exercised or waived his/her procedural due process rights, if any, at which time a final decision shall be made by the Board.

v. Board Action

(1) At its next regularly scheduled meeting following receipt of the MEC's recommendation, the Board may take any of the following actions:

a. Defer the application for further consideration. If, as part of its deliberations pursuant to this section, the Board determines that it requires further information, it may defer action and shall notify the applicant and the Chief of Staff in writing of the deferral and the grounds therefore. If the applicant is to provide the additional information, the Board chair shall advise the applicant, by

Special Notice, including a request for the specific data/explanation or release/authorization, if any, required from the applicant and the time frame for response. Failure by the applicant, without good cause, to respond with the requested information within the time frame specified shall be deemed a voluntary withdrawal of the application without right to the procedural rights set forth in the Medical Staff Bylaws.

b. Adopt, in whole or in part, the recommendation of the MEC.

c. Refer the matter back to the MEC for further consideration and responses to specific questions raised by the Board prior to its final decision. In such instance, the Board shall set a time limit within which the MEC must respond.

d. Reject, in whole or in part, the recommendation of the MEC.

e. Act without benefit of the MEC's recommendation. If the Board, in its determination, does not receive a recommendation from the MEC in timely fashion the Board may, after notifying the MEC of its intent, including a reasonable period of time for response, take action on its own initiative employing the same type of information usually considered by the Medical Staff leadership.

(2) If the Board's action is favorable to the applicant, it shall be effective as its final decision.

(3) If the Board's action is adverse to the applicant and such decision is not based on a prior adverse recommendation of the MEC with respect to which the Practitioner was entitled to a hearing, the Board chair shall promptly inform the applicant, by Special Notice, of the Board's action and of the applicant's procedural rights, if any. The Board shall not take final action on the application until after the applicant has exercised or waived his/her procedural due process rights, if any.

(4) If the Board is to receive an adverse MEC recommendation, the Chief of Staff shall withhold the recommendation and not forward it to the Board until after the Chief of Staff notifies the applicant by Special Notice of the recommendation, and the applicant's right to the procedural rights provided for in the Bylaws, and the applicant either exercises or waives such rights.

(5) In the event that an applicant withdraws his/her initial application within 30 days prior to commencement of a hearing, the withdrawal shall be deemed to be a voluntary withdrawal of the application, and the applicant's file shall be closed.

(6) The Board, through the Chief Executive Officer, shall give notice of its final decision to the applicant by Special Notice and to the Chief of Staff. The Chief of Staff shall, in turn, transmit the decision to the Director of each Department concerned. A decision and notice to appoint/grant Privileges shall include, as applicable: the Medical Staff category to which the applicant is appointed; the Department to which he/she is assigned; the

Privileges he/she may exercise; and any special conditions attached to the appointment and/or Privileges.

vi. Conflict Resolution

Whenever the Board determines that it will decide a matter contrary to the recommendation of the MEC, the matter will be submitted to an ad hoc Joint Conference Committee for review and recommendation before the Board makes its decision. The ad hoc Joint Conference Committee shall be composed of not less than two (2) Medical Staff Appointees selected by the Chief of Staff and not less than two (2) members of the Hospital Board, selected by the Board chair. There shall be an equal number of Medical Staff Appointees and Board members on the Joint Conference Committee. The Chief of Staff and Board chair shall each appoint one (1) of its Joint Conference Committee designees to serve as co-chair of the committee. In the event of any conflict or change in the purpose, composition, meeting, or reporting requirements related to the Board Joint Conference Committee pursuant to the Hospital's Code of Regulations, the Code of Regulations shall govern and this provision will be likewise amended.

vii. Reapplication

Any applicant who has received a final adverse decision regarding Medical Staff appointment and/or Privileges shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of three (3) years. Any such reapplication shall be processed as an initial application. The applicant shall submit information and bear the burden of demonstrating that the basis for the earlier adverse action no longer exists.

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SECTION 5.3. REAPPOINTMENT

5.3-1 Form:

At least one hundred and twenty (120) days prior to the expiration date of a Practitioner's Medical Staff appointment and/or Privileges, Medical Staff Office through the designated CVO shall provide each Practitioner with an application for reappointment/re-grant of Privileges developed by the Medical Staff and approved by the Board.

5.3-2 Content:

The application for reappointment/re-grant of Privileges will include all information necessary to update and evaluate the qualifications of the Practitioner including, but not limited to:

a. The information set forth in Section 5.2-1(b) to the extent applicable to the reappointment/ re-grant of privileges process.

b. Evidence of continuing education obtained during the past twenty- four (24) months, either by a signed attestation or by submission of the appropriate documentation.

5.3-3 Professional Practice Evaluation Data

Focused and Ongoing Professional Practice Evaluation data will be considered in conjunction with applications for reappointment/re-grant of Privileges. In the event of insufficient Ongoing Professional Practice Evaluation data, additional verification may be required from the Practitioner 's primary accredited hospital/health care entity location(s) regarding his/her quality of care.

5.3-4 Processing

a. Transmittal and Verification

Each Practitioner who desires reappointment and/or re-grant of Privileges shall, at least one hundred (100) days prior to his or her appointment/Privilege expiration date, send his or her completed application form for reappointment and/or re-grant of Privileges to Medical Staff Services.

(1) The CVO will notify, by mail and/or telephone, each Practitioner at least eighty (80) days prior to his or her appointment/Privilege expiration date if the Practitioner has not returned his/her application for reappointment and/or re-grant of Privileges. The CVO will give a third and final notice by mail and/or telephone, to each Practitioner at least thirty (30) days prior to his or her appointment/Privilege expiration date if the Practitioner has not returned his or her application for reappointment/re-grant of Privileges.

Failure, without good cause, to return the reappointment/re- grant of Privileges form, and any other information necessary for the completion and evaluation of the application, shall result in termination of the Practitioners' Medical Staff appointment and Privileges as of the last day of the current appointment/Privilege period, without entitlement to the procedural rights provided for in the Medical Staff Bylaws. Any Practitioner who permits his or her appointment and Privileges to terminate will have to reapply for Medical Staff appointment and Privileges, and any such reapplication shall be processed as an initial application subject to the requirements of the Medical Staff Development Plan.

(2) The CVO shall review the application for completeness, collect references, and verify licensure and DEA status, including information obtained from data banks as required by law. Upon determination that the application for reappointment/re-grant of Privileges is complete and all pertinent materials have been secured, the Medical Staff Office shall compile the application form and accompanying material to the Department Director and the Director of Credentialing (as chair of the Credentials Committee). The Department Director shall review and comment to the Credentials Committee with respect to those Practitioners requesting re-grant of Privileges within the Department.

b. Process

Thereafter, the procedure provided for with respect to initial appointment and Privileges shall be followed, except with respect to specific time periods. Except for good cause, all actions by the Credentials Committee, the Medical Executive Committee and Board shall be completed prior to the Practitioner’s Medical Staff appointment/Privileges expiration date. In the event an application is not acted upon prior to the termination date, through no fault of the Practitioner, then the Practitioner may be considered for temporary Privileges to meet an important patient care need consistent with Section 6.5 of these Bylaws.

c. Basis of Recommendation

Each recommendation concerning the reappointment of a Practitioner and the Clinical Privileges to be granted upon reappointment shall be based upon such Practitioner's professional performance, ability, judgment and clinical skills as indicated by the results of quality review activities; his or her professional ethics; his or her discharge of Medical Staff obligations; his or her compliance with the Hospital's Code of Regulations, Medical Staff Bylaws, Policies, and Rules and Regulations and all other established standards, policies and rules of the Hospital; his or her cooperation with other Practitioners, Hospital personnel and with patients; his or her fulfillment of the responsibilities as required herein; and, any other matter bearing on his or her ability and willingness to contribute to quality patient care in the Hospital.

SECTION 5.4. VOLUNTARY RESIGNATION

Any Practitioner or APP Staff submitting a voluntary resignation must submit the request to the Medical Staff Office in writing at least thirty (30) days prior to the effective date of the voluntary resignation. The request is then submitted to the Credentials Committee, MEC and the Board for their information.

SECTION 5.5. ADDITIONAL CLINICAL PRIVILEGES

The process for requesting additional Clinical Privileges for current Practitioners prior to their regularly scheduled reappointment/re-grant review shall be as follows:

1. Any Practitioner requesting additional Clinical Privileges must submit the request in writing to Medical Staff Services. Requests for additional Clinical Privileges are subject to the requirements of the Medical Staff Development Plan.

2. It is the Practitioner's burden to submit adequate and accurate information for a thorough evaluation of his or her request including, but not limited to, evidence of any additional medical education, recommendation from course instructor or proctor and any additional evidence proving current clinical competence for the requested Clinical Privileges.

3. The Practitioner shall meet any criteria developed by the Medical Staff regarding the requested Clinical Privileges, if such criterion exists.

4. If no criterion exists the request will automatically be forwarded to the appropriate person(s), Medical Staff Department(s), and/or committee(s) for review and recommendation in regards to the appropriateness of adding the Clinical Privileges. This review will include, but is not limited to, the standard of care for the Clinical Privileges, the availability of Hospital resources including equipment, personnel, facilities, etc. necessary for the performance of the Clinical Privileges, and the necessary review in connection with insurance or other liability concerns.

    (a) If a positive recommendation (e.g. to provide the service) regarding the requested Clinical Privileges is received from the assigned person(s), Medical Staff Department(s) and/or committee(s) by the Credentials Committee the recommended criterion for the Clinical Privileges will be developed by the appropriate person(s), committee(s), or Department(s). The Credentials Committee will then review and make a recommendation to the Medical Executive Committee regarding the criterion. The Medical Executive Committee will review and make a recommendation to

the Board regarding the criterion. The Board will have final approval of the newly developed criterion.

(b) If the Board determines not to approve the criterion for the new Clinical Privileges, the requesting Practitioner shall be notified by the appropriate party that the Clinical Privileges will not be provided in the Hospital and the Practitioner 's request for such Privileges will be considered automatically and voluntarily withdrawn without right to hearing or appellate review

(c) If the Board approves the criterion for the new Clinical Privileges, the requesting Practitioner may apply for such Privilege in accordance with the requirements and subject to the process set forth in Section 5.2-1 of these Bylaws.

5. Any Practitioner granted additional Clinical Privileges will be subject to a Focused Professional Practice Evaluation on the newly granted Privileges.

SECTION 5.6. AMENDMENT OF CURRENT PRIVILEGE SET

5.6-1 Existing Privilege sets shall be periodically reviewed by the Director of Credentials and the applicable Medical Staff Department Director.

5.6-2 Proposed amendments to existing Privilege sets shall be reviewed and acted upon by the Credentials Committee, the Medical Executive Committee, and the Board.

5.6-3 Amended Privilege sets shall be effective upon Board approval unless otherwise provided by the Board.

SECTION 5.7. APPOINTMENT WITHOUT PRIVILEGES

5.7-1 Due to the limited nature of an appointment without Privileges, applicants to the Active Without Privileges Medical Staff category shall only be required to complete such application and provide such information as required by the applicable Medical Staff category and as the MEC and Board otherwise deem necessary.

5.7-2 If time constraints so require, an application for Active Without Privileges appointment may be acted upon by the Hospital CEO upon recommendation of the Chief of Staff.

5.7-3 Denial of an application for Active Without Privileges appointment shall not trigger procedural due process rights nor shall it create a reportable event for purposes of federal or state law.

SECTION 5.8. FAILURE TO PRACTICE ACTIVELY

5.8-1 Active Staff:

a. An Active Staff Appointee must admit, attend, consult or render professional services on the Hospital premises as documented in the medical record in the care of at least 12 patients each calendar year of appointment and must fulfill the responsibilities of Active Staff. If these conditions are not met, his or her Staff appointment will be automatically reduced to the appropriate staff category for which they meet criteria. Reduction in staff category shall be final 30 days after notice to the Appointee. During those 30 days, the Appointee may submit documentation that the requirements for Active Staff have been met. Upon the expiration of the 30 day period, Hospital Administration shall confirm or reject the automatic reduction, taking into account any documents submitted by the affected appointee.

b. Automatic reduction of Staff category as described in this Section 5.8-1 is not adverse to the Practitioner and shall not give rise to the hearing rights set forth in Article VIII.

5.8-2 Courtesy Staff:

a. A Courtesy Staff Appointee must admit, attend, consult or render professional services on the Hospital premises as documented in the medical record in the care of at least one (1) patient for each calendar year of appointment and must fulfill the responsibilities of Courtesy Staff. If these conditions are not met, the Appointee's Medical Staff appointment/Privileges will be automatically terminated or the appointment will be automatically reduced to Active Without Privileges Staff status if the Practitioner otherwise meets the qualifications for Active Without Privileges Staff. Termination/reduction of Staff category shall be final 30 days after notice to the Appointee. During those 30 days, the Appointee may submit documentation that the requirements for Courtesy Staff have been met. Upon the expiration of the 30 day period, Hospital Administration shall confirm or reject the automatic termination/reduction, taking into account any documents submitted by the affected Appointee.

b. Automatic termination of Staff appointment/Privileges or reduction of Medical Staff category as described in this Section 5.8-2 is not adverse to the Practitioner and shall not give rise to the hearing rights set forth in Article VIII. Reinstatement to Courtesy Staff for an Appointee whose appointment/Privileges have been revoked because of failure to practice actively shall be made only upon application and any such application shall be processed in the same manner as an application for initial appointment/Privileges.

5.8-3 Advanced Practice Professional:

a. An APP must consult or render professional services on the Hospital premises as documented in the medical record in the care of at least one (1) patient for each calendar year of privileges and must fulfill the responsibilities of their category. If these conditions are not met, the APP's privileges will be automatically terminated. Termination shall be final 30 days after notice to the APP or their employer. During those 30 days, the APP or their employer may submit documentation that the requirements for privileges have been met. Upon the expiration of the 30 day period, Hospital Administration shall confirm or reject the automatic termination, taking into account any documents submitted by the affected APP or their employer.

b. Automatic termination of privileges as described in this Section 5.8-3 is not adverse to the APP and shall not give rise to the hearing rights set forth in Article VIII. Reinstatement of an APP whose privileges have been revoked because of failure to practice actively shall be made only upon application and any such application shall be processed in the same manner as an application for initial privileges.

SECTION 5.9. MODIFICATION OF APPOINTMENT/PRIVILEGES

A Staff Appointee may, either in connection with reappointment or at any other time, request modification of his or her Staff category or Clinical Privileges by submitting a written request to the Medical Staff Service Office. Such request shall be processed in substantially the same manner as provided for reappointment/re-grant of Privileges. Adverse decisions may be reportable to governmental authorities, insurers and others. If the applicant has any concerns about the application, he should contact the Director of Credentialing in writing before filing.

SECTION 5.10. REPORTING OF INFORMATION

5.10-1 Adverse Actions:

The authorized Hospital representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action by the Board of Trustees and using the description set forth in the final action as adopted by the Board of Trustees, unless otherwise required by law. The authorized representative shall report any and all revisions of all actions.

SECTION 5.11 WITHHOLDING FOR HOSPITAL'S INABILITY TO ACCOMMODATE APPLICANT

A decision by the Board to withhold staff membership, staff category assignment or particular clinical privileges based on any of the following criteria shall not be deemed to be adverse and shall not entitle the applicant to the procedural rights provided in the Fair Hearing Plan:

(1) On the basis of the hospital's present inability to provide adequate facilities or supportive services for the applicant and his/her patients as supported by documented evidence; or

(2) On the basis of inconsistency with the hospital's current services plan, including duly approved privileging criteria and mix of patient services to be provided; or

(3) On the basis of professional contracts the hospital has entered into for the rendition of services within various specialties.

However, upon written request of the applicant, the application shall be kept in a pending status for the next succeeding three (3) years. If during this period, the Hospital finds it possible to accept applications for staff positions for which the applicant is eligible, and the Hospital has no obligation to applicants with prior pending status, the CEO or his/her designee shall promptly so inform the applicant of the opportunity by special notice.
Within thirty (30) days of receipt of such notice, the applicant shall provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his/her original application. Thereafter, the procedure provided for initial appointment shall apply.

ARTICLE VI:

CLINICAL PRIVILEGES

SECTION 6.1. EXERCISE OF PRIVILEGES

6.1-1 General:

Every Practitioner providing direct clinical services at the Hospital by virtue of Staff appointment or otherwise shall in connection with such practice and except as otherwise provided herein be entitled to exercise only those Clinical Privileges as are specifically granted pursuant to the provisions of these Bylaws and the Staff Rules and Regulations. Said privileges must be within the scope of the license authorizing the practitioner to practice in this state and consistent with any restrictions thereon. The Board shall approve the list of specific privileges and limitations for each category of practitioner and each practitioner shall bear the burden of establishing his/her qualifications to exercise each individual privilege granted.

SECTION 6.2. DELINEATION

6.2-1 Requests:

Each application for appointment and reappointment to the Staff must contain a request for the Clinical Privileges desired by the applicant, if any. Requests for temporary, *locum tenens*, emergency, disaster, or telemedicine Privileges without Medical Staff appointment shall be addressed pursuant to the applicable procedure set forth in the these Bylaws. The request for specific privileges must be supported by documentation demonstrating the practitioner's qualifications to exercise the privileges requested. In addition to meeting the general requirements of these Bylaws for medical staff membership/Privileges, each practitioner must provide documentation establishing that he/she meets the requirements for training, education and current competence set forth in any specific credentialing criteria applicable to the privileges requested. A request by a Practitioner for a modification of Privileges must be supported by documentation of current competence, training and/or experience supportive of the request. All requests for privileges must include at least one (1) peer reference. Requests for Clinical Privileges must be stated specifically and not be broad terms such as "general medicine," or "general practice."

6.2-2 Procedure:

All requests for Clinical Privileges shall be as in the same manner as applications for appointment and reappointment and shall include a query of the National Practitioner Data Bank.

6.2-3 Basis:

Requests for Clinical Privileges shall be evaluated and justified on the basis of information compiled pursuant to applications for appointment and reappointment, as well as on community and hospital need, available facilities, equipment and number of qualified support personnel and resources and as determined by the Medical Staff Development Committee.

For Practitioners who have not actively practiced in the Hospital within the prior appointment period, information regarding current competence shall be obtained in the manner outlined these Bylaws. In addition, those practitioners seeking new, additional or renewed clinical privileges (except those seeking emergency privileges) must meet all criteria for Medical Staff membership as described in these Bylaws, including a query of the National Practitioner Data Bank. When privilege delineation is based primarily on experience, the individual's credentials record should reflect the specific experience and successful results that form the basis for granting of privileges, including information pertinent to judgment, professional performance and clinical or technical skills. Clinical privileges granted or modified on pertinent information concerning clinical performance obtained from other health care institutions or practice settings shall be added to and maintained in the Medical Staff file established for a staff member.

6.2-4 Duration:

Clinical Privileges are granted for a period commensurate with the duration of appointment or reappointment, as applicable, but in no event shall any grant of Clinical Privileges exceed three (3) years.

SECTION 6.3. ADMITTING PRIVILEGES; HISTORY AND PHYSICAL

Only Staff Appointees shall be granted admitting Privileges through the credentialing process.

6.3-1 Dentist:

a. Patients admitted solely for the purposes of receiving services that may be rendered by a licensed Dentist pursuant to Chapter 4715 of the Ohio Revised Code shall be under the supervision of the admitting Dentist. If treatment not within the scope of Chapter 4715 of the Ohio Revised Code is required at the time of admission, or becomes necessary during the course of hospitalization, such treatment shall be under the supervision of a Physician Appointee to the Staff with appropriate Privileges. It shall be the responsibility of the admitting Dentist to make arrangements with a Physician Appointee of the Staff with appropriate Privileges to be responsible for the patient's treatment outside the scope of Chapter 4715 when necessary during the patient's stay in the Hospital. The Dentist is responsible for the patient's history and physical examination that relates to dentistry.

b. The scope and extent of procedures that each Dentist may perform shall be specifically delineated and granted in the same manner as all other Privileges. Professional activities of a Dentist shall be under the oversight of the Director of Surgery. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services.

c. Qualified oral and maxillofacial surgeons may be granted Privileges to admit patients to inpatient services for oral and maxillofacial surgery, to perform and record the history and physical examination, and to assess the medical, surgical and anesthetic risk of an operative and other procedure(s).

6.3-2 Podiatrists:

a. Patients admitted solely for the purposes of receiving services that may be rendered by a Podiatrist pursuant to Revised Code 4731.51 shall be under the supervision of the admitting Podiatrist. If treatment not within the scope of Revised Code 4731.51 is required at the time of admission, or becomes necessary during the course of hospitalization, such treatment shall be under the supervision of a Physician Appointee to the Staff with appropriate Privileges. It shall be the responsibility of the admitting Podiatrist to make arrangements with a Physician Appointee of the Staff with appropriate Privileges to be responsible for the patient's treatment outside the scope of Revised Code 4731.51 when necessary during the patient's stay in the Hospital. The Podiatrist is responsible for the patient's history and physical examination that relates to podiatry; a Physician-Appointee with appropriate Privileges shall be responsible for the medical aspects of the patient's history and physical examination outside of the scope of podiatry.

b. The scope and extent of procedures that each Podiatrist may perform must be specifically delineated and granted in the same manner as all surgical Privileges. Professional activities of Podiatrists shall be under the overall supervision of the Director of Surgery.

6.3-3 Psychologists:

Psychologists are not permitted to admit or co-admit patients to the Hospital. Psychologists may treat only those patients who have been admitted by an Appointee with admitting Privileges and must maintain a consultative relationship with the attending Practitioner during the course of treatment of the patient. A Psychologist may conduct psychological evaluations, but a Physician-Appointee must perform the admission history and physical examination.

6.3-4 History & Physical Examinations & Initial Assessment:

A medical history and physical examination must be completed and documented by a qualified physician or APP who is credentialed and privileged by the Medical Staff to perform a history and physical examination for each patient no more than thirty (30) days

before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. An H&P is required prior to surgery and prior to procedures requiring anesthesia services, regardless of whether care is being provided on an inpatient or outpatient basis. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the history and physical shall specifically document the circumstances surrounding the need for additional acute care.

When the history and physical examination is conducted greater than thirty (30) days before admission or registration, an update must be completed and documented by a qualified physician or APP who is credentialed and privileged by the Hospital's medical staff to perform a history and physical examination. An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician (as defined in Section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and Hospital policy. If the history and physical and/or updates are completed by an APP, the findings, conclusions and assessment of risk must be endorsed by a qualified physician prior to surgery, invasive diagnostic or therapeutic interventions, induction of anesthesia, or other major high-risk procedures.

The update must accompany an examination for any changes in the patient's condition since the patient's history and physical examination was performed that might be significant for the planned course of treatment. If, upon examination, the qualified physician or APP finds no change in the patient's condition since the history and physical examination was completed, he/she may indicate in the patient's medical record that the history and physical examination was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the history and physical examination was completed.

At minimum, the medical history and physical examination must contain an age specific assessment of the patient including (a) the chief complaint, which is a statement that establishes medical necessity in concise manner based upon the patient's own words; (b) a history of the present illness outlining the location, quality, severity, duration, timing, context and modifying factors of the complaints; (c) medications, including both prescribed and over-the-counter remedies; (d) allergies and intolerances, including a description of the effects caused by each agent; (e) past medical and surgical history; (f) health maintenance/immunization history; (g) family history and social history, including socioeconomic factors, sexual and substances use/abuse issues, advance directives and potential discharge or disposition challenges; (h) comprehensive physical examination, including vital signs, general appearance, mental status and abnormal and pertinent normal findings from each body system; (i) diagnostic data that is either available or pending at the time of admission; (j) clinical impression outlining the provisional diagnoses and/or

differential diagnoses for the patient's symptoms; and (k) the plan outlining the evaluation and treatment strategy, any limitations including patient and/or family requests and discharge planning initiation.

The Medical Staff shall recommend, and the Board shall approve a policy identifying the outpatient surgeries and procedures requiring a history and physical examination as a prerequisite and, if required, the scope of such history and physical. The Medical Staff and Board shall also define via policy any outpatient surgeries or procedures for which an assessment may be conducted and documented in lieu of a comprehensive history and physical examination. Any such assessment in lieu of a comprehensive history and physical examination must be completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services. The assessment must be completed and documented by a qualified physician (or other Practitioner or APP who has been credentialed and granted privileges to perform such assessments). The outpatient surgical and procedural assessment policy and process described in this paragraph shall only apply to those patients receiving specific outpatient surgical or procedural services and shall be based upon the following:

1. Patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure.

2. Nationally recognized guidelines and standards of practice for assessment of specific types of patients prior to specific outpatient surgeries and procedures

3. Applicable state and local health and safety laws.

An initial assessment of all patients must be performed by the responsible Medical Staff member within twenty-four (24) hours of admission, and an initial assessment of all patients in the intensive care/critical care unit must be performed no later than two (2) hours after admission or sooner if warranted by the patient's condition.

SECTION 6.4. LOCUM TENENS

Practitioners seeking locum tenens Privileges shall submit an application for such Privileges and shall have such application processed in accordance with Section 5.2-1. An approved application for Privileges as a locum tenens shall be valid for a period of three (3) years. Privileges shall be granted for a period not to exceed sixty (60) days as recommended by the MEC and approved by the Board. In exceptional circumstances a locum tenens may initially qualify for temporary Privileges. If privileges renewed after 60 days, certain components may need to be updated. For purposes of this Section, the term "locum tenens" shall include Practitioners providing temporary coverage during another Practitioner's

absence (e.g. due to illness, vacation etc.) and those Practitioners who provide additional temporary staffing at the Hospital as needed from time to time at the request of the Hospital.

SECTION 6.5. TEMPORARY PRIVILEGES

Temporary Privileges may be granted only in the circumstances and under the conditions below. Special requirements of consultation and reporting may be imposed by the Department Director responsible for supervision of the Practitioner exercising temporary Privileges as applicable. Under all circumstances, the Practitioner requesting temporary Privileges must agree in writing to abide by the Bylaws, the Medical Staff Rules and Regulations and all applicable Hospital and Medical Staff policies in matters relating to his/her activities in the Hospital.

Upon recommendation of the Chief of Staff, (or in the absence of the Chief of Staff, the Chief of Staff Elect or Immediate Past Chief of Staff), the CEO may grant temporary Privileges on a case-by-case basis in the following circumstances:

a) New Applicant- To an applicant for new Privileges but only after: receipt of a completed and fully verified application in accordance with section 5.2 and 5.5 that raises no concerns and is awaiting review and approval by the Medical Executive Committee (MEC) and the governing body; consultation with the Director of the applicable Department and a positive recommendation by the Credentials Committee; or, if so authorized by the Credentials Committee, the Director of Credentialing (as the Credentials Committee chair). Along with the completed application, the record must establish that the applicant has no current or previously successful challenges to his/her licensure; has not been subject to the involuntary termination of his/her medical staff appointment at another organization; has not been subject to any involuntary limitation, reduction, denial or loss of privileges; and, has not been suspended or terminated from any Federal Healthcare Program.

Temporary Privileges may be granted in this circumstance for a period not to exceed the pendency of the application or ninety (90) days, whichever is less. Under no circumstances may temporary Privileges be initially granted or renewed if the application is still pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information .

b) Important Patient Care Need: To a Practitioner to meet an important patient care need (e.g., specific patient or class of patients necessary to prevent a lack or lapse of services in a needed specialty) but only after: receipt of a written request for the specific Privileges desired; receipt of a copy of appropriate current licensure, DEA controlled substances registration, and proof of adequate professional liability insurance; a fully positive written reference specific to the Practitioner's current competence for the Privileges being requested from a responsible medical staff authority at the Practitioner's current hospital affiliation;

results of a National Practitioner Data Bank query; and results of a criminal background check.

Temporary Privileges may only be granted in this circumstance for a period of thirty (30) days, but may be renewed for additional thirty (30) day periods if the important patient care need continues.

SECTION 6.6. EMERGENCY PRIVILEGES

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

In case of an emergency, any Practitioner, to the degree permitted by his or her license, regardless of his or her Medical Staff category or Clinical Privileges shall be permitted to do, and shall be assisted by Hospital personnel in doing, everything possible to save the life of a patient or to save a patient from serious harm. A Practitioner utilizing emergency Privileges shall, upon request, provide to the Board a written statement explaining the circumstances giving rise to the emergency. The Practitioner exercising emergency Privileges shall obtain all consultative assistance deemed necessary and arrange for appropriate post-emergency care.

When an emergency situation no longer exists, the emergency Privileges are automatically terminated and such Practitioner must request the Privileges necessary to continue to treat the patient. In the event that such Privileges are denied or he or she does not desire to request Privileges, the Chief of Staff, in consultation with the applicable Department Director, shall assign the patient to a Medical Staff Appointee with appropriate Privileges. A Practitioner shall not be entitled to the procedural rights afforded by the Medical Staff Bylaws because of denial of a request for emergency Privileges or because of any termination of emergency Privileges.

SECTION 6.7. DISASTER PRIVILEGES

Disaster Privileges may be granted to licensed volunteer Practitioners when the Hospital's emergency operations plan is activated in response to a disaster and the Hospital is unable to meet immediate patient needs.

The Chief Executive Officer or Chief of Staff may grant such disaster Privileges on a case-by-case basis after verification of a valid government-issued picture identification in addition to at least one of the following: (i) primary source verification of licensure; (ii) a current license to practice; (iii) a current picture identification card from a health care organization that identifies professional designation; (iv) identification indicating 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 organization or group; (v)

identification indicating the individual has been granted authority to render patient care, treatment or services in disaster circumstances by a government entity; or, (vi) confirmation of the identity of the volunteer Practitioner and his/her qualifications by a Hospital employee or Practitioner with Hospital Privileges.

The granting of disaster Privileges shall be done in the same manner as temporary Privileges to meet an important patient care need, except that primary source verification of licensure may be performed after the situation is under control and as circumstances allow. It is anticipated that these disaster Privileges may be granted to state-wide and out-of-state Practitioners as necessary.

Primary source verification of licensure shall occur as soon as the disaster is under control or within seventy-two (72) hours from the time the volunteer Practitioner presents to the Hospital, whichever comes first. If primary source verification cannot be completed within seventy-two (72) hours (due to, for example, no means of communication or a lack of resources), verification shall be performed as soon as possible. In such event, the Hospital will document why primary source verification could not be performed in the required time frame; evidence of the volunteer Practitioner's demonstrated ability to continue to provide adequate care, treatment, and services; and, an attempt to rectify the situation as soon as possible. A reassessment/decision must be made within seventy-two (72) hours after initial disaster Privileges have been granted to determine if there should be a continuation of disaster Privileges for the volunteer Practitioner.

All Practitioners who receive disaster Privileges shall be issued a temporary Hospital identification badge to assist Hospital and Medical Staff personnel to readily identify these volunteer Practitioners.

The activities of Practitioners who receive disaster Privileges shall be managed by and under the supervision of the Chief of Staff or appropriate Department Director.

The disaster Privileges shall cease upon alleviation of the circumstances of disaster as determined by the CEO.

SECTION 6.8. TERMINATION

The CEO or the Chief of Staff may, at any time, terminate any or all of a Practitioner 's temporary, locum tenens, disaster or telemedicine Privileges. Where the life or well-being of a patient is determined to be endangered, the Practitioner 's temporary, locum tenens, disaster, or telemedicine Privileges may be terminated by any person entitled to impose a summary suspension pursuant to the Medical Staff Bylaws.

A Practitioner who has been granted temporary, locum tenens, disaster, or telemedicine Privileges is not entitled to the procedural rights provided in the Medical Staff Bylaws. A Practitioner shall not be entitled to the procedural due process rights set forth in the Medical Staff Bylaws because a request for temporary, locum tenens, disaster, or

telemedicine Privileges is denied, in whole or in part, or because all or any portion of such Privileges are terminated, not renewed, restricted, suspended or otherwise limited, modified or monitored in any way.

In the event of any such termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the applicable Department Director. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner.

SECTION 6.9. ADVANCED PRACTICE PROFESSIONALS

Advanced Practice Professional may be granted clinical privileges without Medical Staff Membership. APP's are not entitled to the Fair Hearing process outlined in Article VIII.

6.9-1 CATEGORIES

An Advance Practice Professional ("APP") shall be identified as an individual, other than a Practitioner, who is qualified to render direct or indirect medical or surgical care under the supervision of a Practitioner who has been afforded privileges within their scope of practice to provide such care in the Hospital. This formal organization of APPs who are eligible to be granted clinical privileges pursuant to these Bylaws shall be called the "APP Staff." Such persons may be employed by physicians on the staff; but whether or not so employed, must be under the supervision and direction of a staff physician who maintains clinical privileges to perform procedures in the same specialty area as the APP (with the exception of CRNAs, who may be supervised by an anesthesiologist or other physician deemed competent to supervise the administration of anesthesia as defined in the Medical Staff Rules and Regulations) and not exceed the limitations of practice set forth by their respective licensure.

6.9-2 QUALIFICATIONS

a. Only APPs holding a license, certificate or other official credential as provided under state law, shall be eligible to provide specified services in the Hospital as delineated by the MEC and approved by the board.

b. <u>APPs must:</u>

1. Document their professional experience, background, education, training, demonstrated ability, current competence and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital;

2. Establish, on the basis of documented references, that they adhere strictly to the ethics of their respective provisions, work cooperatively with others and are willing to participate in the discharge of APP responsibilities

3. Have professional liability insurance in the amount required by these bylaws;

4. Provide a needed services within the Hospital; and

5. Unless permitted by law and by the Hospital to practice independently, provide written documentation that a Medical Staff appointee has assumed responsibility for the acts and omission of the APP and responsibility for directing and supervising the APP.

6.9-3 PREROGATIVES

a. Upon establishing experience, training, and current competence, APPs shall have the following prerogatives:

1. To exercise judgment within the APP's area of competence, providing that a physician member of the Medical Staff has the ultimate responsibility of patient care;

2. To participate directly, including writing orders to the extent permitted by law, in the management of patients under the supervision or direction of a member of the Medical Staff; and

3. To participate as appropriate in-patient care evaluation and other quality assessment and monitoring activities required of the staff, and to discharge such other staff functions as may be required from time-to- time.

6.9-4 CONDITIONS OF APPOINTMENT

a. APP's shall be credentialed in the same manner as outlined in Article V of the Medical Staff Bylaws for credentialing Practitioners. Each APP shall be assigned to at least one (1) of the clinical departments and shall be granted clinical privileges relevant to the care provided in that department. The Board in consultation with the MEC shall determine the scope of the activities which each APP may undertake. Such determinations shall be furnished in writing to the APP and shall be final and non-appealable, except as specifically and expressly provided in these bylaws

b. Appointment of APP's must be approved by the Board and may be limited, suspended, or terminated by the Board or the CEO. Adverse actions or recommendations affecting APP privileges shall not be covered by the provisions of the Fair Hearing Plan. However, the affected APP shall have the right to request to be heard before the MEC with an opportunity to rebut the basis for termination. Upon receipt of a written request, the MEC shall afford the APP an opportunity to be heard by the MEC concerning the APP's grievance (an "interview"). Before the appearance, the APP shall be informed of the general nature and circumstances giving rise to the action, and the APP may present information relevant thereto. A record of the appearance shall be made. The MEC shall, after conclusion of the investigation, submit a written decision simultaneously to the Board and to the APP.

c. The APP shall have a right to appeal to the Board any decision rendered by the MEC. Any request for appeal shall be required to be made within fifteen (15) days after the date of the receipt of the MEC decision. The written request shall be delivered to the Chief of Staff and shall include a brief statement of the reasons for the appeal. If appellate review is not requested within such period, the APP shall

be deemed to have accepted the action involved which shall thereupon become final and effective immediately upon affirmation by the MEC and the Board. If appellate review is requested the Board shall, within fifteen (15) days after the receipt of such an appeal notice, schedule and arrange for appellate review. The Board shall give the APP notice of the time, place and date of the appellate review which shall not be less than fifteen (15) days nor more than ninety (90) days from the date of the request for the appellate review. The appeal shall be in writing only, and the APP's written statement must be submitted at least five (5) days before the review. New evidence and oral testimony will not be permitted. The Board shall thereafter decide the matter by a majority vote of those Board members present during the appellate proceedings. A record of the appellate proceedings shall be maintained.

d. APP privileges shall automatically terminate upon revocation of the privileges of the APP's supervising physician member, unless another qualified physician indicates his/her willingness to supervise the APP and complies with all requirements hereunder for undertaking such supervision. In the event that an APP's supervising physician member's privileges are significantly reduced or restricted, the APP's privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan. In the case of CRNAs who are supervised by the operating surgeon, the CRNA's privileges shall be unaffected by the termination of a given surgeon's privileges so long as other surgeons remain willing to supervise the CRNA for purposes of their cases.

e. If the supervising Practitioner employs or directly contracts with the APP for services, the Practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, cause of actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the APP, negligence of such APP, the failure such APP to satisfy the standards of proper care of patients, or any action by such APP beyond the scope of his/her license or clinical privileges.

6.9-5 RESPONSIBILITIES

a. Each APP shall:

1. Provide his/her patients with continuous care at the generally recognized professional level of quality;

2. Abide by the Medical Staff Bylaws and other lawful standards, policies, and Rules & Regulations of the Medical Staff, and personnel policies of the Hospital, if applicable;

3. Discharge any committee functions for which he/she is responsible.

4. Cooperate with members of the Medical Staff, credentialed APPs, administration, the Board of Trustees and employees of the Hospital;

5. Adequately prepare and complete in a timely fashion the medical and other required records for which he/she is responsible;

6. Participate in performance improvement activities and in continuing professional education

7. Abide by the ethical principles of his/her profession and specialty; and

8. Notify the CEO and the Chief of Staff immediately if:

    a. His/Her professional license in any state is suspended or revoked;
    b. His/Her professional liability insurance is modified or terminated;
    c. He/She is named as a defendant, or is subject to a final judgement or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;
    d. His/Her specialty board certification expires, is voluntarily surrendered, or is revoked;
    e. He/She voluntarily or involuntarily relinquishes his/her licensure to practice any profession in any jurisdiction;
    f. He/She voluntarily or involuntarily relinquishes his/her Nation Drug Enforcement Agency (DEA) number or state licensure certificate;
    g. His/Her APP staff membership or clinical privileges are voluntarily or involuntarily revokes, reduced, relinquished, limited or restricted in any health care facility;
    h. His/Her patient management is the subject to an investigation by a state medical board;
    i. He/She is excluded from participation in federal or state health insurance; including Medicare or Medicaid;
    j. He/She participates in a voluntary or mandatory drug and/or alcohol rehabilitation program;
    k. He/She has any criminal charges, other than minor traffic violations brought/initiated against him/her;
    l. He/She is subject to current, pending investigation or challenge to licensure, DEA certification, medical staff membership or clinical privileges at any health care facility, or participation in federal or state insurance; or
    m. He/She ceases to meet any of the standards or requirements set forth herein for continuing enjoyment of APP appointment and/or clinical privilege.

Failure to provide any such notice, as required above, shall result in immediate loss of the APP's clinical privileges, without right of fair hearing procedures.

9. Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Hospital;

10. Refuse to engage in improper inducements for patient referral; and

11. Attest that he/she suffers from no health problems which could affect ability to perform the functions of APP requested privileges prior to initial exercise of privileges, and participate in the Hospital drug testing program (if drug testing program is applicable).

6.9-6 CONFLICTS OF INTEREST

a. Each APP granted clinical privileges at the Hospital must acknowledge and comply with the following standards concerning conflicts of interest:

1. The best interests of the community, APP's and the Hospital are served by APP's who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision-making process of the APP may be altered by interests or relationships which might in any instance, either intentionally or coincidentally, bear on that member's opinions or decision. Therefore, it is considered to be in the best interest of the Hospital and the APP for relationships of any APP which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

2. No APP Staff member shall use his/her position to obtain or accrue any improper benefit. All APP Staff members shall at all times avoid even the appearance of influencing the actions of any other staff member or employee of the Hospital or Corporation.

3. Upon being granted clinical privileges and upon any grant of reappointment and/or renewal of clinical privileges, each APP shall file with the MEC a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a APP, and/or a member of the community, which in any way and to any degree may impact on the finances or operations of the Hospital or its staff, or the Hospital's relationship to the community, including but not limited to each of the following:

a. Any leadership position on another APP or Medical Staff or educational institution that creates a fiduciary obligation on behalf of the Practitioner, including, but not limited to membership on the governing body, executive committee, or service or department

chairmanship with an entity or facility that competes directly or indirectly with the Hospital:

b. Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Hospital;
c. Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Hospital; or
d. Business practices that may adversely affect the Hospital or community.

4. This disclosure requirement is not a punitive process and is only intended to identify those conflicts of interest which may affect patient safety or quality of care. This disclosure requirement is to be construed broadly, and an APP should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure requirement will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

5. Between regular disclosure dates, any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting. The Medical Staff Coordinator will provide each MEC member with a copy of each APP's written disclosure at the next MEC meeting following filing by the APP for review and discussion by the MEC

SECTION 6.10. PROFESSIONAL PRACTICE EVALUATION

6.10-1 Focused Professional Practice Evaluation. The Hospital's focused professional practice evaluation (FPPE) process is set forth, in detail, in the Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Policy and Procedure, as such policy may be amended from time to time, and shall be implemented for all:

a. Practitioners & APPs requesting initial Privileges; (b) existing Practitioners & APPs requesting Privileges during the course of an appointment/Privilege period; and (c) in response to concerns regarding a Practitioner's & APPs ability to competently provide patient care. The FPPE period shall be used to determine the Practitioner's & APPs current clinical competence and ability to perform the requested Privileges.

6.10-2 Ongoing Professional Practice Evaluation. Upon conclusion of the FPPE period, ongoing professional practice evaluation (OPPE) shall be conducted on all Practitioners & APPs

with Privileges. The Hospital's OPPE process is set forth, in detail, in the Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Policy and Procedure, as such policy may be amended from time to time, and requires the Hospital to gather, maintain, and review data on the performance of all Practitioners and APPs with Privileges on an ongoing basis.

ARTICLE VII:

CORRECTIVE ACTION, SUMMARY SUSPENSION, AUTOMATIC SUSPENSION/TERMINATION

SECTION 7.1. COLLEGIAL INTERVENTION

Prior to initiating corrective action against a member of the Medical Staff for professional conduct or competency concerns, the Medical Staff leadership or Board (through the Hospital's CEO as an agent of the Board) may elect to attempt to resolve the concern(s) informally provided that nothing in this section shall be construed as an obligation of the Hospital or Medical Staff leadership to engage in informal remediation prior to implementing formal corrective action on the basis of a single incident or incidents.

SECTION 7.2. CORRECTIVE ACTION

7.2-1 Grounds for Corrective Action:

A professional review action may be initiated against a Medical Staff Appointee whenever the Practitioner engages in or exhibits actions, statements, or conduct, either, that is, or is reasonably likely to be:

a. Contrary to the Medical Staff Bylaws, Rules & Regulations, or Medical Staff or Hospital policies;

b. Detrimental to patient safety or to the quality or efficiency of patient care in the Hospital;

c. Disruptive to patient care activities or Hospital operations;

d. Damaging to the Medical Staff's or the Hospital's reputation;

e. Below the applicable standard of care; or

f. In violation of any law or regulation relating to patient care, the Practitioner's activities at the Hospital, or to federal or state healthcare reimbursement programs.

7.2-2 Authorization to Initiate:

Any of the following may request that corrective action be taken or initiated:

a. An officer of the Medical staff.

b. A Director of any Department in which the Practitioner exercises Privileges.

c. Any standing committee or subcommittee of the Medical Staff (including the MEC) or chair thereof.

d. The Chief Executive Officer.

e. The Board or the Chair thereof.

7.2-3 Requests and Notices:

All requests for professional review action shall be in writing, submitted to the Medical Executive Committee and supported by reference to the specific conduct or activities, which constitute the grounds for the request. If the professional review action is initiated by the MEC, it shall reflect the basis for its recommendation in its minutes. The Chief of Staff shall promptly notify the CEO in writing of all requests for corrective action received by the Medical Executive Committee and shall inform the CEO on a timely and ongoing basis of all action in connection therewith.

7.2-4 Investigation:

a. Upon receipt of a request for corrective action, the MEC shall act on the request. The MEC's investigation shall be deemed to begin as of the start of the MEC meeting at which the request for corrective action is to be presented to it. The MEC may conduct such investigation itself, assign the task to a standing or ad hoc committee, or may refer the matter to the Board for investigation and resolution. This investigative process is not a "hearing" as that term is used in these Bylaws and shall not entitle the Practitioner to any procedural rights. The investigative process may include, without limitation, a meeting with the Practitioner involved, with the individual or group who made the request; and/or with other individuals who may have knowledge of or information relevant to the events involved. If the investigation is conducted by a group or individual other than the MEC or the Board, that group or individual shall submit a written report of the investigation, which may be reflected by minutes, to the MEC as soon as is practical after its receipt of the assignment to investigate. The MEC may, at any time in its discretion, and shall, at the request of the Board, terminate the investigative process and proceed with action as provided below.

b. If the MEC has reason to believe that the Practitioner's conduct giving rise to the request for corrective action was result of a physical or mental impairment, the MEC may require the Practitioner to submit to an impartial physical or cognitive evaluation in accordance with the Provider Wellness Policy. The MEC shall select the independent third party service provider who will conduct the examination at the Practitioner's expense.

7.2-5 Medical Executive Committee Action:

As soon as practical after the conclusion of the investigative process, if any, the MEC shall act upon the request for corrective action. Its action may include, without limitation, the following:

a. Closure of the investigation for lack of sufficient supportive evidence;

b. A warning;

c. Letter of reprimand;

d. Imposition of a focused professional practice evaluation with retrospective review of cases and/or other review of professional behavior but without requirement of prior or concurrent consultation or direct supervision;

e. Recommendation of imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limit's the Practitioner's ability to exercise Privileges;

f. Recommendation of reduction, suspension or revocation of Clinical Privileges;

g. Recommendation of reduction of Medical Staff category or limitation of any Medical Staff Prerogatives directly to the Practitioner's delivery of patient care;

h. Recommendation that the Appointee be suspended or that his or her appointment be terminated.

7.2-6 Procedural Rights

Any action by the MEC pursuant to Section 7.2-5 e, f, g, or h (where such action materially restricts a practitioner's exercise of privileges) or any combination of such actions, shall entitle the physician or dentist to the procedural rights as specified in the provisions of Article VIII and the Fair Hearing Plan. The Board may be informed of the recommendation, but shall take no action until the member has either waived his/her right to a hearing or completed the hearing.

7.2-7 Other Action

If the MEC's recommendation as provided in Section 7.2-5 a, b, c, or d (where such action does not materially restrict a practitioner's exercise of privileges), such recommendation,

together with all supporting documentation, shall be transmitted to the Board. The Fair Hearing Plan shall not apply to such actions.

7.2-8 Board Action

When routine corrective action is initiated by the Board, the functions assigned to the MEC under this Section shall be performed by the Board, and shall entitle the practitioner to the procedural rights as specified in the Fair Hearing Plan.

7.2-9 Additional Action.

The commencement of corrective action procedures against an Appointee shall not preclude the summary suspension or automatic suspension or termination of the Medical Staff appointment and/or all, or any portion, of the Appointee's Privileges in accordance with the procedures set forth in Sections 7.3, 7.4, and 7.5 of this Article.

SECTION 7.3. SUMMARY SUSPENSION

7.3-1 Initiation of Summary Suspension:

Whenever a Practitioner's conduct is of such a nature as to require immediate action to protect the life, health or safety of any patient(s) or to reduce the substantial likelihood of injury to any patient, employee, or other person present in the Hospital, any of the following have the authority to summarily suspend the Medical Staff appointment and/or all, or any portion of, the Privileges of such Practitioner:

a. The Chief of Staff

b. Chief of Staff Elect

c. Immediate Past Chief of Staff

d. The applicable Department Director

e. The CEO of the Hospital

f. The Board or its Chair

g. The MEC

A summary suspension is effective immediately. The person or group imposing the suspension shall immediately inform the Chief Executive Officer of the suspension and he/she shall promptly give Special Notice thereof to the Practitioner.

7.3-2 MEC Action:

As soon as reasonably feasible after such summary suspension, but in no event later than seven (7) days after imposition of the suspension, a meeting of the MEC shall be convened to review and consider the action taken. The MEC may modify, continue or terminate the summary suspension. However, in the case of a summary suspension imposed by the Board or CEO, the MEC may recommend modification, continuation or termination of the suspension, but the suspension shall remain in place until action by the Board or CEO.

7.3-3 Board or CEO Action:

In the case of a summary suspension imposed by the Board or CEO, the Board or CEO as applicable shall review the MEC recommendation as soon possible after the MEC action but in no event more than fourteen (14) days after the imposition of the summary suspension. The Board or CEO may modify, continue or terminate the summary suspension.

7.3-4 Procedural Rights:

Not later than fourteen (14) days following the original imposition of the summary suspension, the Practitioner shall be advised by Special Notice of the MEC's determination or, in the case of a summary suspension imposed by the CEO or Board, of the MEC's recommendation as to whether such suspension should be terminated, modified, or sustained, and the Board or CEO's decision regarding the MEC's recommendation. The Special Notice shall apprise the Practitioner of his/her rights, if any, pursuant to Article VIII of these Bylaws. A summary suspension that is lifted within fourteen (14) days of its original imposition on the grounds that it was not necessary shall not be deemed an Adverse action and shall not entitle the Practitioner to any of the rights provided in Article VIII of these Bylaws.

SECTION 7.4. AUTOMATIC SUSPENSION OF PRIVILEGES

The following events shall result in an automatic suspension or limitation of a Practitioner's or APPs appointment and/or Privileges, as applicable, without recourse to the procedural rights set forth in Article VIII.

7.4-1 Grounds

a. Licensure. Upon the order of the applicable state agency suspending or imposing conditions or restrictions on a Practitioner's or APP's license or Practitioner's or APP's license has expired, the Practitioner shall immediately and automatically be suspended from the staff and practicing in the Hospital.

b. Drug Enforcement Administration (DEA) Number. A Practitioner or APP whose DEA certification/number or equivalent state credential is revoked, suspended, voluntarily relinquished, or has expired shall immediately and automatically be

suspended from the staff and practicing in the Hospital, until such time as the registration is reinstated.

c. Medical Records. Failure to complete medical records within the prescribed time and in accordance with the procedure specified in the Medical Staff Rules and Regulations shall result in an automatic suspension of Privileges except for previously scheduled procedures and patients admitted prior to the automatic suspension. This automatic suspension shall be lifted immediately upon completion of all outstanding incomplete medical records.

d. Professional Liability Insurance. Failure to continuously maintain or to provide proof of professional liability insurance upon request in the amount and kind as specified by the Board from time to time shall result in an automatic suspension of the Practitioner's or APP's Medical Staff appointment and/or Privileges. This automatic suspension shall be lifted immediately upon obtaining the requisite professional liability insurance and provision of satisfactory proof of such insurance to the Hospital.

e. Failure to Pay Dues. Failure to pay Medical Staff dues within a timely manner shall result in an automatic suspension of Privileges except for previously scheduled procedures and patients admitted prior to the automatic suspension. This automatic suspension shall be lifted immediately upon receipt of payment in full of all dues owed.

f. Medicare/Medicaid Suspension. A Practitioner's or APP's Medical Staff appointment and/or Privileges shall be automatically suspended in the event Medicare, Medicaid or any other governmental health care program suspends the Practitioner or APP from participation in such program.

g. Failure to appear/cooperate. Failure of a Practitioner or APP to appear at any meeting with respect to which he/she was given such special notice and/or failure to comply with any reasonable directive of the MEC shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the Practitioner or APP's clinical privileges as the MEC may direct.

7.4-2 Impact of Automatic Suspension/Limitation.

Except as otherwise provided above, during such period of time when a Practitioner's or APP's appointment and/or Privileges, as applicable, are suspended or limited he/she may not, as applicable, exercise any Prerogatives of appointment or any Privileges at the Hospital, participate in on-call coverage, schedule surgery, otherwise provide professional services within the Hospital for patients, or admit patients under the name of another Practitioner.

7.4-3 Medical Executive Committee Action Following Automatic Suspension.

As soon as practicable after an automatic suspension, the matter shall be referred to the Medical Executive Committee for a determination as to whether corrective action should be initiated.

7.4-4 Reinstatement following Automatic Suspension.

The lifting of the action or inaction that gave rise to an automatic suspension or limitation on the Practitioner's or APP's Medical Staff appointment and/or Privileges, as applicable, shall result in the automatic reinstatement of the Practitioner's or APP's Medical Staff appointment and/or Privileges; provided, however, that to the extent the suspension or limitation remained in effect for a period of more than thirty (30) days, the Practitioner or APP shall be obligated to provide such information as Medical Staff Services shall reasonably request to assure that all information in the Practitioner's or APP's credentials file is current.

SECTION 7.5. AUTOMATIC TERMINATION OF PRIVILEGES

7.5-1 The following events shall result in an automatic termination of a Practitioner's or APP's Medical Staff appointment and Privileges without recourse to the procedural rights set forth in Article VIII.

a. Licensure. Upon the order of the applicable state agency revoking a Practitioner's or APP's license, the Practitioner's or APP's Medical Staff appointment and/or Clinical Privileges shall automatically be terminated.

b. Medicare/Medicaid Exclusion. A Practitioner's or APP's Medical Staff appointment and/or Privileges shall automatically terminate in the event Medicare, Medicaid or any other governmental health care program excludes the Practitioner or APP from participation in such program.

c. Failure to Pay Dues. If a Practitioner or APP fails to pay dues for eighteen (18) months, the Practitioner's or APP's Medical Staff appointment and/or Privileges shall automatically terminate.

d. Professional Liability Insurance. In the event the Practitioner or APP fails to provide proof of professional liability insurance within thirty (30) days of automatic suspension of the Practitioner's or APP's Privileges pursuant to §7.4.1(d), the Practitioner's or APP's Medical Staff appointment and/or Privileges shall automatically terminate as of thirty-first (31st) day.

e. Conviction of a Crime. If a Practitioner or APP pleads guilty to, is found guilty of, or pleads no contest to a felony or other serious offense that involves (a) violence or abuse upon a person; (b) conversion, embezzlement, or misappropriation of property; (c) fraud, bribery, evidence tampering, or perjury;

or (d) a drug offense, the Practitioner's or APP's Medical Staff appointment and/or Privileges shall be immediately and automatically terminated.

SECTION 7.6. CONTINUITY OF PATIENT CARE

Upon the imposition of a summary suspension or the occurrence of an automatic suspension or automatic termination, the Chief of Staff shall provide for alternative coverage for the Practitioner's patients in the Hospital. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner. The affected Practitioner shall confer with the substitute Practitioner to the extent necessary to safeguard the patient.

ARTICLE VIII:

HEARINGS AND REVIEW

Refer to Appendix “A”- Fair Hearing Plan.

ARTICLE IX:

OFFICERS OF THE MEDICAL STAFF

SECTION 9.1. OFFICER ENUMERATED

9.1-1 Elected Officers:

Elected officers of the Medical Staff shall consist of the Chief of Staff, Chief of Staff Elect, Immediate Past Chief of Staff, the Director of Medicine, and the Director of Surgery.

9.1-2 Appointed Officers:

The appointed officers of the Medical Staff shall be the Director of Credentialing and the Medical Director of the Hospital Quality Outcomes Committee.

SECTION 9.2. QUALIFICATIONS

9.2-1 Chief of Staff and Chief of Staff Elect:

The Chief of Staff must be an Appointee of the Active Staff at the time of nomination and remain so during the term of office. Failure to maintain such status shall immediately create a vacancy in this office. Nominees for Chief of Staff Elect must have been Appointees of the Active Staff for a minimum of two (2) years) by the close of the nominating period, to be eligible for nomination. The Chief of Staff elect must complete a two (2) year term on MEC prior to commencement of the Chief of Staff position. Nominees shall be Board Certified or demonstrate a comparable level of experience and competence.

9.2-2 Department Directors:

The Director of Surgery and Director of Medicine shall be Appointees of the Active Staff at the time of nomination and remain so during the term of office. Failure to maintain such status shall immediately create a vacancy in the respective office. Nominees must have been Appointees of the Active Staff for a minimum of two (2) years in their department by the close of the nominating period, to be eligible for nomination. Nominees shall be Board Certified or demonstrate a comparable level of experience and competence.

9.2-3 Director of Credentialing and Medical Director of the Hospital Quality Outcomes Committee:

The Director of Credentialing and Medical Director of the Hospital Quality Outcomes Committee shall be appointed by the Chief of Staff in consultation with CEO and with the approval of the elected officers of the Medical Staff. Preference will be given to existing Staff Appointees. In the event an appropriate candidate cannot be identified in the existing Staff, the Director of Credentialing and Medical Director of the Hospital Quality Outcomes Committee may be appointed from outside the Staff, subject to the Practitioner satisfying the eligibility requirements for and obtaining Staff appointment/Privileges. The Director

of Credentialing and Medical Director of the Hospital Quality Outcomes Committee must remain Appointees of the Active Staff during term of office. Failure to maintain such status shall immediately create a vacancy in the respective office. Nominees shall be Board Certified or demonstrate a comparable level of experience and competence.

SECTION 9.3. ELECTION AND APPOINTMENT OF OFFICERS

9.3-1 Nominating Process:

a. A nominating committee shall be named by the Chief of Staff on or prior to April 1st in the year prior to the expiration of his or her term. The nomination committee shall consist of three (3) members of the Active Staff.

b. The nominating committee shall accept nominations for a thirty (30) day period beginning April 1st in the year of an election. The entire Medical Staff will be notified in writing of the nominating period by April 1st. Nominations will be accepted only if the nominee meets the necessary qualifications and has agreed to serve. Any Appointee may make a nomination for Chief of Staff Elect and any qualified Active Staff Appointee may nominate himself or herself. No individual can run for more than one position, whether officer or at-large, on the Medical Executive Committee. Nominations for Director of Surgery and Director of Medicine may be made only by members of the respective departments. All Appointees with voting privileges, however, shall be entitled to vote for both the Director of Medicine and the Director of Surgery. The nominating committee will be responsible to nominate a qualified candidate.

9.3-2 Election Process:

a. At the close of the nominating period, if only one (1) candidate has been nominated, vote may be by voice. If two (2) or more individuals are nominated for office, vote must be by written ballot at a regular or special meeting of the Medical Staff.

b. The nominee receiving the majority of votes cast shall be elected to the office. Where there are three (3) or more candidates for an office and no candidate receives a majority of those voting, balloting shall continue and the name of the candidate receiving the fewest votes shall be eliminated until a majority vote is obtained for one (1) candidate. Voting by proxy shall not be permitted.

c. The election process will be completed by July 1st.

9.3-3 Approval:

The elected and appointed officers of the Medical Staff will be submitted to the Board of Trustees at their July meeting of the election year. The election and appointment of Medical Staff officers will be subject to approval by the Board of Trustees, which may

withhold approval only by majority vote based on the same grounds required for removal of officers in Section 9.5.

9.3-4 MEC:

Newly elected and/or appointed officers of the Medical Staff shall become non-voting members of the Medical Executive Committee on August 1st in the year of an election. They will take office as of January 1st in the following year. Between August 1st and January 1st, the officers-elect shall have the same attendance requirements as presiding officers.

9.3-5 Automatic Succession of the Chief of Staff Elect and the Chief of Staff:

a. The Chief of Staff shall automatically succeed to the office of Immediate Past Chief of Staff upon completion of his/her term as Chief of Staff upon approval of the MEC and the Board of Trustees.

b. The Chief of Staff Elect shall automatically succeed to the office of Chief of Staff upon completion of his/her term as Chief of Staff Elect upon approval of the MEC and the Board of Trustees.

SECTION 9.4. TERMS OF OFFICE

Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff Year following his election. Each officer shall serve until the end of his or her term, resignation, or removal by action of the Medical Staff or by action of the Board of Trustees.

SECTION 9.5. REMOVAL OF OFFICERS

9.5-1 An officer shall be removed from office if a two-thirds majority of the Active Staff Appointees votes in favor of removal. Grounds for removal shall include, but are not limited to, inability to perform the duties and responsibilities of the office. Actions directed towards removing an officer may be initiated by submission to the Medical Executive Committee of a petition seeking removal of an officer, signed by not less than fifty percent (50%) of the Active Staff Appointees or by petition signed by greater than 50% of the Board of Trustees.

9.5-2 Notwithstanding any of the foregoing, the Board may remove any officer by majority vote on the following grounds only: professional impairment, failure or inability to perform the duties of office or profession, or conduct contrary to the best interests of the Hospital and the medical community, including but not limited to any act, omission or condition satisfying the criteria for professional review action. The Board shall not act arbitrarily in

removing or withholding an appointee from staff office, but shall act only on the basis of reliable and substantial evidence.

SECTION 9.6. VACANCIES IN MEDICAL STAFF OFFICERS

9.6-1 In the office of Chief of Staff: In the event of a vacancy in the office of the Chief of Staff, the Chief of Staff Elect will serve the remainder of the vacating Chief of Staff's current term followed by the Chief of Staff Elect's own term as Chief of Staff.

9.6-2 In the office of Chief of Staff Elect: In the event of a vacancy in the office of the Chief of Staff Elect, a special election shall be conducted, as soon as reasonably possible, in accordance with the procedure set forth in section 9.3-1 through 9.3-3, to fill the vacancy for the remainder of the current term. If an incoming Chief of Staff Elect has been elected, that practitioner shall take office for the remainder of the vacating Chief of Staff's current term. Thereafter, the Chief of Staff Elect may serve his/her own term as the Chief of Staff Elect

9.6-3 In the office of the Immediate Past Chief of Staff: In the event of a vacancy in the office of the Immediate Past Chief of Staff, the position will remain vacant until the subsequent Chief of Staff automatically succeeds to the office of Immediate Past Chief.

9.6-4 Vacancies for the Director of Medicine, Director of Surgery, and Member-at-Large shall be filled by a qualified Appointee, nominated by the remaining members of the Medical Executive Committee, subject to the approval of: (i) a majority of the voting Staff Appointees present at the next regular Medical Staff meeting that is at least thirty (30) days after the Medical Executive Committee nomination; and (ii) the Board of Trustees. Vacancies in appointed Medical Staff Officers shall be filled promptly by appointment by the CEO subject to the approval of the elected Medical Staff Officers. The Chief of Staff and/or Chief of Staff Elect shall temporarily continue the duties of the vacant Director of Medicine/Surgery position(s) until an elected member can seat the position.

SECTION 9.7. DUTIES AND FUNCTIONS

9.7-1 Chief of Staff:

The Chief of Staff shall serve as the chief administrative officer of the Medical Staff. In the temporary absence of the Chief of Staff, the other members of the MEC shall assume all duties and have the authority of the Chief of Staff in the following order, if available: Chief of Staff Elect, Immediate Past Chief of Staff, Director of Medicine; Director of Surgery; Director of Credentialing. The Chief of Staff shall:

a. Be responsible to the Board, in conjunction with the MEC, for the quality and efficiency of clinical services and professional performance within the hospital and for the effectiveness of patient care evaluations and maintenance functions delegated to the staff; work with the Board in implementation of the Board's quality, performance, efficiency and other standards.

b. In concert with the MEC and clinical departments, develop and implement methods for credentials review and for delineation of privileges; along with the continuing medical education programs, utilization review, monitoring functions and patient care evaluation studies.

c. Serve as the presiding officer and is responsible for the agenda of all regular, annual and special Medical Staff meetings.

d. Serve as Chair of the Medical Executive Committee and as an ex-officio member of all Medical Staff Committees.

e. Appoint Medical Staff representation and designate chairs to Medical Staff Committees except when membership and/or chairmanship is specified in the Board or Medical Staff Bylaws or other approved documents such as the Quality Review Plan.

f. Act in coordination with the CEO in all matters of mutual concern within the Hospital.

g. Be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, and Hospital policies, for implementation of sanctions where indicated, and for Staff's compliance with procedural safeguards in all instances where professional review action has been requested against a Practitioner.

h. Attend all Board of Trustees meetings; if unable to personally attend, appoint another MEC member to attend in the Chief of Staff's absence.

i. Communicate the concerns, needs and grievances of the Staff to the Board and CEO.

j. Serve as the Medical Staff spokesperson for the Staff's external professional and public relations.

k. Appoint or recommend, as applicable, Medical Staff representation to serve as advisors to Hospital and Board Committees except where membership is specified by Board or Medical Staff Bylaws.

l. Be responsible that proper notification of all Staff meetings is given.

m. Be responsible that accurate and complete minutes for all Medical Staff and Medical Executive Committee meetings are maintained.

n. Be responsible that complete and accurate accounts of all receipts and disbursements from Medical Staff moneys and funds are maintained. Deposit all moneys and funds in the name of and into the credit of Clinton Memorial Hospital Medical Staff, in such a depository or depositories as to be designated by the Medical Staff.

o. Render at any Medical Executive Committee meeting and Medical Staff meeting or to any Appointees of the Medical Staff when properly requested correct statements showing the true condition and balance of accounts of all funds and moneys entrusted to the Medical Staff or collected, managed or disbursed by the Medical Staff in connection with the Chief of Staff's duties and functions.

p. Perform such duties commensurate with the office of Chief of Staff as may, from time to time, be reasonably requested by the Medical Executive Committee, CEO, or Board of Trustees.

q. Be responsible for Medical Staff compliance with accreditation or surveying entities such as The Joint Commission.

r. Assist in coordinating the educational activities of the Medical Staff.

s. Confer with the CEO and Department Directors on at least a quarterly basis as to whether there exists sufficient space, equipment, staffing, and financial resources or that the same will be available within a reasonable time to support each privilege requested by applicants to the Medical Staff; and report on the same to the MEC and to the Board.

t. Assist the Department as to the types and amounts of data to be collected and compared in determining and informing the Medical Staff of the professional practice of its members.

9.7-2 Chief of Staff Elect

a. Serve as a voting member of the Medical Executive Committee and as a voting or *Ex Officio* (non-voting) member of such other Medical Staff committees as provided for in the Medical Staff governing documents.

b. Assume the duties of the Chief of Staff in his or her absence or in the event of a vacancy in the office of Chief of Staff.

c. Have and exercise such other authority and powers as provided by the Medical Staff governing documents.

d. Fulfill such other duties

9.7-3 Immediate Past Chief of Staff

a. Serve as a voting member of the Medical Executive Committee and as a voting or *Ex Officio* (non-voting) member of such other Medical Staff committees as provided for in the Medical Staff governing documents.

b. Have and exercise such other authority and powers as provided by the Medical Staff governing documents.

c. Fulfill such other duties pertaining to his or her office as the Chief of Staff may reasonably request.

9.7-4 Department Directors:

The Director of each Medical Staff Department, as described in Section 10.1, shall be an officer of the Medical Staff and shall:

a. Serve on the Medical Executive Committee.

b. Serve on the Medical Staff Quality Improvement Committee as ex-officio members.

c. Prepare the agenda and serve as the presiding officer at the respective department meetings. In the temporary absence of the Director at the respective department meeting, the relevant Director shall appoint another Appointee of the Staff in that Department to preside at the meeting, who shall temporarily have all duties and authority of the Director in the Director's absence.

d. Be responsible that the department oversees the following functions:

1. Clinically related activities of the department;

2. Administratively (unless otherwise provided for by the Hospital) related activities of the department;

3. Integration of the department into primary functions of the organization;

4. Coordination and integration of interdepartmental and intradepartmental services;

5. Development and implementation of policies and procedure which guide and support the department and the provision of care, treatment and services within the department;

6. Ongoing surveillance of the professional performance of all independent individuals who have delineated Clinical Privileges appropriate to the department;

7. Continuous assessment and improvement of the quality of care, treatment, and services provided;

8. Orientation and continuing education of all members of the department;

9. Participation in the planning for space and resources needed by the department;

10. Recommending space and other resources needed by the department and, where appropriate, assessing and recommending to Hospital administration off site sources for needed patient care, treatment, and services not already provided by the department or Hospital;

11. Recommending to the Medical Staff the criteria for Clinical Privileges that are relevant to the care provided in the department;

12. Making recommendations to the MEC regarding Clinical Privilege delineations for members of the department;

13. Making recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and service in the department;

14. Assist in the determination of the qualifications and competence of department personnel who are Practitioners, APPs, or other persons who are not Practitioners and who provide patient care, treatment, and services; and

15. Maintenance of quality control programs.

e. Report to the Medical Executive Committee concerning the following items regarding the Director's department (i) all professional and administrative activities within the department, (ii) the quality of patient care rendered by Appointees of the department, and (iii) the effective performance of quality improvement activities conducted by or delegated to the department.

f. Enforce the Hospital and Medical Staff Bylaws, Rules and Regulations and Hospital policies and procedures within the Director's department.

g. Perform such duties commensurate with the office of Department Director as may, from time to time, be reasonably requested by the Chief of Staff, Medical Executive Committee, CEO, or Board of Trustees.

h. Within the Director's department implement committee actions taken by the Medical Executive Committee.

i. Recommend criteria for Clinical Privileges that would be granted to Practitioners and APPs in the Director's department.

j. Review and comment to the Director of Credentialing on Clinical Privileges for Practitioners and APPs in the Director's department.

9.7-5 Director of Credentialing:

a. Serve on the Medical Executive Committee.

b. Serve as Chair of the Credentials Committee.

c. Annually review credentialing policies and procedures and submit recommendations regarding the same to the Medical Executive Committee or Departments, as appropriate, for recommendation to the Board of Trustees.

d. Develop and review annually the criteria by which credentialing of each Staff category and Clinical Privileges shall be granted. Consultations may be obtained with the Director of Medicine or Director of Surgery, an ad hoc committee of Staff Appointees, outside consultants, or other written resource material.

e. Review all information relevant to the qualification of applicants for appointment or reappointment to the Medical Staff category and Clinical Privileges requested and make recommendations for approval or disapproval on each applicant to the Credentials Committee and the Medical Executive Committee.

f. Enforce the Hospital Code of Regulations, and Medical Staff Bylaws, Policies, Rules and Regulations and Hospital policies and procedures.

g. Perform such other duties commensurate with the office of Director of Credentialing as may, from time to time, be reasonably requested by the Chief of Staff, Medical Executive Committee, CEO, or Board of Trustees.

SECTION 9.8. CONFLICT OF INTEREST OF MEDICAL STAFF MEMBERS

9.8-1 The best interests of the community, Medical Staff and the Hospital are served by Medical Staff members who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision-making process of the Medical Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally bear on that member's opinions or decision. Therefore, it is considered to be in the best interest of the Hospital and the Medical Staff for relationships of any Medical Staff member which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

9.8-2 No Medical Staff member shall use his/her position to obtain or accrue any benefit. All Medical Staff members shall at all times avoid even the appearance of influencing the actions of any other staff member or employee of the Hospital or Corporation, except through his/her vote, and the acknowledgment of that vote, for or against opinions or actions to be stated or taken by or for the Medical Staff as a whole or as a member of any committee of the Medical Staff.

9.8-3 Upon being granted appointment to the Medical Staff and/or clinical privileges, and upon any grant of reappointment and/or renewal of clinical privileges, each Medical Staff

member shall file with the MEC a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a Medical Staff members, and/or a member of the community, which in any way and to any degree may impact on the finances or operations of the Hospital or its staff, or the Hospital's relationship to the community, including but not limited to each of the following:

a. Any leadership position on another Medical Staff or educational institution that creates a fiduciary obligation on behalf of the practitioner, including but not limited to membership on the governing body, executive committee, or service or department chairmanship with an entity or facility that competes directly or indirectly with the Hospital;

b. Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Hospital;

c. Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Hospital; or

d. Business practices that may adversely affect the hospital or community.

9.8-4 This disclosure requirement is not a punitive process and is only intended to identify those conflicts of interest which may affect patient safety or quality of care. This disclosure requirement is to be construed broadly, and a Medical Staff member should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure requirement will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

9.8-5 In addition to the foregoing, a new Medical Staff leader (defined as any member of the MEC, department director, officer of the Medical Staff, and/or members of the Medical Staff who are also members of the Hospital's Board of Trustees) shall file the written statement immediately upon being elected or appointed to his/her leadership position. Between regular disclosure dates, any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting. The MEC Secretary will provide each MEC member with a copy of each leader's written disclosure at the next MEC meeting following filing by the leader for review and discussion by the MEC.

a. Medical Staff leaders with a direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly with the Hospital shall not be eligible for service on the Medical Executive Committee, Credentials Committee, Bylaws Committee, Quality Assurance Committee or the Board of Trustees.

b. Medical Staff leaders shall abstain from voting on any issue in which the Medical Staff leader has an interest other than as a fiduciary of the Medical Staff. Failure to disclose a conflict as required by this Section 9.8 or failure to abstain from voting on an issue in which the Medical Staff member has an interest other than as a fiduciary of the Medical Staff may be grounds for corrective action. In the case of Medical Staff leaders, a breach of these provisions is deemed sufficient grounds for removal of a breaching leader from his/her leadership position by the remaining members of the MEC or the Board on majority vote.

9.8-6 No Practitioner will be denied appointment, reappointment or Privileges at the Hospital solely because of ownership, direct or indirect, in an entity or facility that competes directly or indirectly with the Hospital.

ARTICLE X:

COMMITTEES AND DEPARTMENTS

SECTION 10.1. GENERAL PROVISIONS

10.1-1 The Medical Staff shall have the following standing committees: the Medical Executive Committee, Medical Staff Quality Improvement Committee, the Credentials Committee, and the Cancer Committee. Various other committees as needed to perform the activities of the Medical Staff may be organized by the Medical Staff. All committees and ad hoc committees shall keep and maintain minutes. The CEO and/or his designee shall be an ex-officio member of all Medical Staff Committees. Other Hospital personnel appointed by the CEO shall serve as ex-officio members to the respective committees.

10.1-2 The Medical Staff shall also be organized into the following Departments: the Surgical Department and the Medical Department. Additional Departments may be organized only pursuant to Section 10.6-4.

SECTION 10.2. MEDICAL EXECUTIVE COMMITTEE

10.2-1 Composition:

a. Shall consist of the Chief of Staff, Chief of Staff Elect, Immediate Past Chief of Staff, Director of Surgery, Director of Medicine, Director of Credentialing, Medical Director of Hospital Quality Outcomes Committee, and two (2) Members-at-Large. The Chief Executive Officer shall participate as an ex-officio member. No individual may serve in more than one position on the Medical Executive Committee.

b. Members-at-Large are not Medical Staff Officers, however, they are elected at the same time and in the same manner as the elected Medical Staff Officers as provided in Section 9.3. Members-at-Large shall serve as Medical Executive Committee members for a two (2) year term, commencing on the first day of the Medical Staff Year following the election; provided, however, Members-at-Large shall become non-voting members of the Medical Executive Committee on August 1st in the year of an election. All MEC Members, including Members-at-Large, may be removed from the Medical Executive Committee, and vacancies in the position(s) shall be filled, in the same manner and process set forth for the removal of elected Medical Staff officers in Section 9.5 and the filling of vacancies in Section 9.6.

c. The duties of the Members-at-Large are to serve on the Medical Executive Committee and to improve access and communication between the Medical Staff and the Medical Executive Committee.

d. Nominees for Members-at-Large must have been Appointees of the Active Staff for a minimum of two (2) years in their department to be eligible for election. Nominees shall be board certified or demonstrate a comparable level of experience and competence. Failure to maintain Active Staff appointment shall immediately create a vacancy in the Member-at-Large position.

e. All Active Medical Staff Appointees, of any discipline or specialty, are eligible for membership on the MEC; provided, however, that at all times, the majority of the voting members of the MEC shall be Physicians who are Active Medical Staff Appointees. In the event the foregoing provisions do not result in the majority of the voting MEC members being Active Staff Physician-Appointees, then a number of Active Staff Physician-Appointees necessary to create such a majority shall be appointed as members of the MEC by the Chief of the Staff.

10.2-2 Meetings:

Shall meet at least once a month at a time and place specified by the Chief of Staff.

10.2-3 Reports:

Shall submit timely reports of their activities to the Board of Trustees.

10.2-4 Duties:

a. Fulfilling the Medical Staff's accountability to the Board for the quality of the overall medical care rendered to the patients in the Hospital.

b. Submission of recommendations concerning health care in the Hospital and community to the Board.

c. Receive and act on reports and recommendations from the Medical Staff Departments, Medical Staff committees and other assigned activity groups.

d. Act on behalf of the Medical Staff in intervals between Medical Staff meetings.

e. Coordinate and implement the activities of and policies adopted by the Staff.

f. Institute and pursue professional review action, when warranted in accordance with these Bylaws, including making recommendations to the Board regarding termination, suspension or other action of Medical Staff appointment and Clinical Privileges.

g. Submit recommendations regarding medical-administrative matters to the Board through the CEO.

h. Ensure that the Staff is informed of The Joint Commission Accreditation standards, accreditation status of the Hospital and the Staff's active involvement in all phases of the accreditation process.

i. Develop and monitor compliance with these bylaws, the rules and regulations, policies and other Hospital standards.

j. Represent and act on behalf of the Staff, subject to the limitations as may be imposed by these Bylaws.

k. Oversee the implementation of a Continuing Education Program by the Medical Staff Advisor to the Hospital Education Committee.

l. Developing and implementing programs to inform the staff about Practitioner/APP health and recognition of illness and impairment in Practitioners/APPs, and addressing prevention of physical, emotional and psychological illness.

m. Review and submit recommendations to the Board on the applications for Staff appointment and the delineation of Clinical Privileges, and ensuring that appropriate evaluations of applicants are conducted in instances where there is doubt about an applicant's ability to perform the Privileges requested.

n. Review the credentialing criteria submitted by the Credentialing Director and submit recommendations to the Board on the mechanism used to review credentials and to delineate individual Clinical Privileges.

o. Communicate appropriately to the Medical Staff.

p. Submit recommendations to the Board on Medical Staff structure.

q. Submit recommendations to the Board on the participation of the Medical Staff in organization performance-improvement activities.

r. Submit recommendations to the Board on the mechanism for fair-hearing procedures.

s. Submit recommendations to the Board on Medical Staff policies and procedures with input from the relevant Department, as appropriate.

SECTION 10.3. MEDICAL STAFF QUALITY IMPROVEMENT COMMITTEE

10.3-1 Process:

The Medical Staff Quality Improvement Committee shall act pursuant to the Medical Staff Quality Improvement Committee Peer Review Charter and Policy and Procedure. Recommendations for amendment or repeal of the Medical Staff Quality Improvement

Committee Peer Review Policy and Procedure or any provision contained therein may be made to the Board of Trustees after recommendation of the Medical Staff Quality Improvement Committee and the Medical Executive Committee.

10.3-2 Membership:

a. The Medical Staff Quality Improvement Committee shall be a multidisciplinary committee consisting of the Physician Chair and a representative from each of the following specialties: General Medicine, a Medical Subspecialty, Family Practice, Surgery, a Surgical Subspecialty, OB/GYN, Emergency Medicine, Anesthesiology, Radiology and Pathology. The Chief of Staff, Director of Medicine, Director of Surgery, Director of Credentialing, Chief Nursing Officer, Medical Director of the Hospital Quality Outcomes Committee, and the Director of Quality are ex-officio members without a vote. The MEC members-at-large may be invited as non-voting guests. At no time may more than three Medical Staff Quality Improvement Committee members simultaneously serve on the MEC unless there are vacancies on the MEC resulting from lack of willing participants from the otherwise qualified Medical Staff.

b. Committee members are appointed by the Chief of Staff, subject to the approval of the Medical Executive Committee. The Chair is appointed by the Chief of Staff, subject to the approval of the Medical Executive Committee. Eligibility to serve as Chair requires past service of at least one year on the Medical Staff Quality Improvement Committee.

c. Non-voting members upon invitation of the Medical Staff Quality Improvement Committee include an administration representative, nursing executive representative, Quality Outcomes Coordinator, and such other licensed independent practitioners and Hospital representatives.

10.3-3 Meetings:

The Medical Staff Quality Improvement Committee shall meet at least six times per year at a time and place designated by the Chair. Action carries upon vote of a majority of voting members present at a meeting at which a quorum is present.

10.3-4 Duties:

a. The Medical Staff Quality Improvement Committee shall be responsible for the evaluation and improvement of Practitioner/APP performance, including but not limited to the following areas:

1. Skill and judgment related to effectiveness and appropriateness in performing the clinical privileges granted, including but not limited to:

(a) Medical assessment and treatment of patients;

(b) Use of operative and other procedures and adverse anesthesia events;

(c) Use of medications;

(d) Use of blood and blood components;

(e) Significant departures from established patterns of clinical practice; and

(f) The use of developed criteria for autopsies.

2. Ability to meet the customer service needs of patients and other caregivers.

3. Cooperation with patient safety and rights, rules, and procedures.

4. Effective and efficient use of hospital clinical resources.

5. Interpersonal interactions with colleagues, hospital staff, and patients.

6. Participation and cooperation with Medical Staff responsibilities.

7. Accurate, timely, and legible completion of patient medical records.

b. The Medical Staff Quality Improvement Committee shall be responsible for:

1. Providing review, recommendations, and/or approval of protocols, standard of care, policies and procedures needing Practitioner approval, where appropriate.

2. Conducting focused reviews of practitioner's/APP's performance when the practitioner's/APP's performance requires further evaluation.

3. Communicating findings, conclusions, recommendations and actions to improve performance to the Medical Executive Committee on at least a quarterly basis.

4. Implementing changes required to improve performance.

5. Communicating information about individual practitioner/APP performance for use in privileging decisions.

SECTION 10.4. CREDENTIALS COMMITTEE

10.4-1 Composition:

The Credentials Committee shall consist of three (3) physician members including the Director of Credentials, and two (2) members of the Active Staff appointed by the Chief

of Staff and approved by the CEO. The two (2) members may not be members of the Medical Executive Committee. Each member, except the Director of Credentials, will serve a three (3) year term, which shall be staggered so as to always have an experienced member on the Committee. The CEO and Director of Quality are ex-officio members without a vote.

10.4-2 Meetings:

The Credentials Committee shall meet monthly or as called upon by the Director of Credentials or the CEO. Minutes of the Credentials Committee meetings will be presented to the Medical Executive Committee and full Board of Trustees for action .

10.4-3 Duties:

a. Review all information relevant to the qualification of applicants for appointment to the Staff category and/or Clinical Privileges requested and make recommendation regarding same to the Medical Executive Committee as set forth in these Bylaws.

b. Review all information relevant to the qualification of a Practitioner/APP for, as applicable, reappointment/re-grant of Privileges and make recommendation regarding same to the Board as set forth in these Bylaws

c. May annually review credentialing policies and procedures and submit recommendations regarding same to the Medical Executive Committee.

SECTION 10.5. OTHER MEDICAL STAFF COMMITTEES

10.5-1 Cancer Committee:

a. Composition

The Cancer Committee shall be composed of Staff Appointees who are involved in all aspects of the care of cancer patients. This would include, but not be limited to, the specialties of primary care, surgery, gynecology, diagnostic radiology, radiation oncology, medical oncology, and pathology. Other members shall be appointed to provide input from other aspects of caring for cancer patients. These shall include, but not be limited to, the cancer program administrator, oncology nurse, social worker/care manager, tumor registrar, Director of Quality, hospice representative(s), American Cancer Society navigator, rehabilitation services, community outreach representative, hospital administration representative, radiation oncology technician and staff education representative.

b. Chair

The Chair shall be an Appointee in good standing of the Medical Staff at the time of appointment and must remain in good standing during his or her tenure. The

Chair shall be qualified by training, and experience, and possess a special interest in the Hospital Cancer Program. The Chair of the Cancer Committee is appointed by the Chief of Staff. The Chair is responsible for the overall monitoring and evaluation of the committee and reports to the Medical Executive Committee.

c. Meetings

The Cancer Committee shall meet on a quarterly basis. The Cancer Committee is responsible for conducting cancer conferences (Tumor Board). Representatives from all appropriate disciplines should attend and participate in this activity. Minutes shall be presented to the Medical Executive Committee for information.

d. Objectives:

Organize, publicize, implement, and evaluate regular educational and consultative cancer conferences that are multidisciplinary, Hospital-wide and case-oriented.

1. To assure that consultative services in the major disciplines are available to cancer patients in the institution.

2. To develop and evaluate the annual goals and objectives for the clinical, community outreach, quality improvement, and programmatic endeavors related to cancer care.

3. To assure that cancer rehabilitation services are available and are being used.

4. To encourage the development of a support care system for the patient dying from cancer.

5. To ensure that the clinical program includes appropriate activities in cancer prevention, screening, diagnosis, treatment, follow-up, rehabilitation, and continuing care.

e. Duties:

1. The Committee must ensure that patients have access to consultative services in all disciplines.

2. The Committee is responsible for assuring that educational programs, conferences, and other clinical activities cover the entire spectrum of cancer.

3. The Committee will perform at least two (2) improvement activities per year regarding cancer patient care, either directly or by review of quality improvement data supplied by other committees.

4. The Committee shall ensure that two prevention or early detection programs are provided on-site or coordinated with other facilities or local agencies.

5. The Committee on a yearly basis completes and documents the required studies that measure quality and outcomes.

10.5-2 Conflict Resolution Committee

The Conflict Resolution Committee shall provide an ongoing process for managing conflict among leadership groups. Said Committee shall consist of two (2) members of the Medical Staff who are selected by the Medical Executive Committee (and may or may not be members of the Board), two (2) non-physician Board members who are selected by the Board Chair, and the CEO. The Committee shall meet, as needed, specifically when a conflict arises that, if not managed, could adversely affect patient safety or quality of care. When such a conflict arises, the Committee shall meet with the involved parties as early as possible to resolve the conflict, gather information regarding the conflict, work with the parties to manage and when possible, to resolve the conflict, and to protect the safety and quality of patient care.

10.5-3 Physician Advisors to Hospital Areas:

a. The Medical Staff shall assign physician advisors to the various clinical areas of the Hospital to aid these areas in more effectively accomplishing their duties. These advisors are responsible for being available on short notice for consultation with unit or area managers when a physician's input is needed. The advisor and the unit manager can ask other providers to help in these deliberations, as they feel necessary. All advisors will be appointed by the Chief of Staff and will serve two (2) year terms unless the advisor's position itself determines that they will be an advisor. The Chief of Staff would normally arrange for these appointments as one of their first duties when they take office as Chief of Staff.

b. The following is a list of possible advisor positions along with likely qualifications for the positions. This list is not meant to include all possible advisor positions in that they can be created or retired by agreement between the Chief of Staff and the Hospital Administration on the basis of need.

Mother Baby Care Unit - Newborn	Pediatrician
Mother Baby Care Unite - Obstetrics	OB/Gyn or FP with OB privileges
ICU	Hospitalist, Cardiologist or Pulmonologist
Emergency Room	Emergency Medicine
Inpatient/Outpatient Units - Medical	Director of Medicine*
Inpatient/Outpatient Units - Surgical	Director of Surgery*
Radiology Department	Radiologist

Pathology Department	Pathologist
Home Care	Primary Care Physician
Infection Control	Chief of Staff Elect
Cancer Program	Oncologist or Surgeon

* *Contracted position: verify individual to contact*

SECTION 10.6. DEPARTMENTS

10.6-1 Description:

The Medical Staff shall be organized into two Departments: the Surgery Department and the Medicine Department.

a. The Surgery Department shall consist of general surgeons, surgical sub-specialists, anesthesiologists, pathologists, podiatrists and obstetrician/ gynecologists.

b. The Medicine Department shall consist of medical sub-specialists, family practitioners, pediatricians, internists, emergency medicine physicians, psychiatrists, radiologists, and neurologists.

10.6-2 Meetings:

a. Departments shall meet at a time and place specified by the Director. Departments shall meet as often as necessary to fulfill their responsibilities. Ad hoc subcommittees, which may be multi-disciplinary or involve only a certain specialty, may be formed to address particular issues at the discretion of the Department Director.

b. Departments and subcommittees shall keep minutes of their meetings and shall send a copy of their minutes to the Medical Executive Committee.

10.6-3 Directors:

a. Each Department shall have a Director as provided in Section 9.7.

b. Each Department shall participate in Medical Staff and Hospital activities as described in Section 9.7-4 regarding the duties of the Director.

10.6-4 New Departments:

a. Additional Departments not described in these Bylaws may be created from time to time by the Medical Staff in the following manner.

b. Departments or groups of Appointees may submit a request to the MEC for creation of a new Department in a specific area of practice. The MEC shall review such requests and determine whether or not to create such an additional

Department. If the MEC determines a new Department should be created, it shall make such recommendation to the Board for final approval. Creation of a new Department shall require approval of the MEC and the Board and require appropriate revisions to the Bylaws.

ARTICLE XI:

MEETINGS

SECTION 11.1. ANNUAL, REGULAR AND SPECIAL

11.1-1 Annual:

a. The Annual Meeting of the Medical Staff shall be held at the Hospital or designated meeting place in the Month of December of each year at a date and time to be designated by the Chief of Staff.

b. The following order of business shall be observed:

Call to Order

Minutes of the Previous Annual Meeting
Minutes of the Previous Regular Monthly Meeting
Minutes of any Special Meeting
Annual Report of Chief of Staff
Reports of Directors
Report of CEO
Old Business
New Business
Adjournment

11.1-2 Regular Meetings:

a. Regular meetings of the Medical Staff shall be held at the Hospital on the second (2nd) Tuesday of the months of February, April, June, August, and October.

b. The order of business for the regular meetings shall be as follows:

Call to Order

Minutes of the Previous Meeting
Minutes of any Special Meeting
Report of Chief of Staff
Reports of Directors
Report of CEO
Old Business
New Business
Adjournment

11.1-3 Special Meetings:

a. Special meetings of the Medical Staff may be called, from time to time, by the Board, Chief of Staff, the Medical Executive Committee, or on the written request of any twenty-five percent (25%) of the Active Staff Appointees to Medical Staff. The written request for a special meeting shall be presented to the Chief of Staff, if available, and if not, to the Medical Executive Committee.

b. Notice of the special meeting shall be provided pursuant to Section 11.2-1.

c. No business shall be transacted at any special meeting that is not stated in the meeting notice.

SECTION 11.2. GENERAL PROVISIONS

11.2-1 Notice of Meetings:

a. Written or printed notice stating the place, day and hour of any annual, regular or special Medical Staff meeting, or of any committee not held pursuant to resolution or pursuant to the schedule set forth in Sections 11.1 or 11.2, shall be delivered either personally or by mail (including electronic mail) to each person entitled to be present thereat not less than three (3) business days before the date of any special meetings, and not less than five (5) business days for any regular or annual meetings. Notice of special meetings must contain a statement as to the purpose or purposes of holding such a meeting. The Chief of Staff or Committee Chair must notify the CEO of the time and place of all meetings not less than three (3) business days prior to the meeting.

b. Attendance at any meeting shall be deemed to constitute proper notice to the attendees and waiver of any notice requirements not satisfied.

11.2-2 Quorum:

For any Medical Staff meeting at which proposed action or amendment(s) to the Medical Staff Bylaws or the Medical Staff Rules and Regulations occurs, medical staff members will be given due notice and information in advance of the meeting, majority rules of those medical staff members present at the meeting. For any other Medical Staff, Department or committee meeting at which any other action is proposed, a quorum shall constitute those Medical Staff members present (but not less than 2 members or unless otherwise defined within the committee charter and majority will rule.

a. Action on Bylaws and Rules and Regulations.

Action on the Bylaws and Rules and Regulations shall be pursuant to Section 13.3-1 and Section 13.4-2.

b. All Other Action.

For all action other than amendments to the Bylaws or Rules and Regulations, the action of a majority of the voting Appointees present, at a meeting at which a quorum exists, shall constitute the action of the Staff or committee. Action may be taken without a meeting by a committee or the Medical Staff by written ballot. The procedure for action by written ballots shall be the same as set forth above in Section 11.2-2(a), except that the vote may be taken by either anonymous numbered ballots or signed ballots, the total number of signed, returned ballots must at minimum equal one (1) voting Appointee, and means of action is defined as a simple majority of the signed, returned ballots.

11.2-3 Minutes:

Minutes of all meetings shall be prepared by the Medical Staff Services Coordinator or designee and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be presented by the presiding chair, approved by the attendees, and forwarded to the Medical Executive Committee. It is each Practitioner's responsibility to hold all minutes strictly confidential. A permanent file of the minutes of each meeting shall be maintained in the Medical Staff Office.

SECTION 11.3. ATTENDANCE REQUIREMENTS

11.3-1 Medical Staff Quality Improvement Committee, Credentials Committee:

Members of the Medical Staff Quality Improvement Committee and Credentials Committee must attend at least 66% of the respective committee meetings held. Failure to attend by an officer may result in the removal of the officer pursuant to, Section 9.5. Failure to attend by a non-officer committee member may result in removal of the member after review and discussion by the committee chair and approval of the Medical Executive Committee.

11.3-2 Medical Executive Committee:

Members of the Medical Executive Committee must attend at least 75% of the respective committee meetings held. Failure to attend by an officer may result in the removal of the officer from that committee pursuant to Section 9.5. Failure to attend by a member-at-large member may result in the removal of the member after review and approval by the Medical Executive Committee.

11.3-3 Departments, Hospital Committees:

Members of the Departments are encouraged to attend their respective meetings. Physician advisors who are specifically invited to attend a particular Hospital committee meeting shall use their best efforts to attend.

11.3-4 Medical Staff Meetings:

Medical Staff Appointees are encouraged to attend Medical Staff meetings. Although attendance records will be kept, meeting attendance will not be used by the Director of Credentialing in evaluating Practitioners at the time of reappointment/re-grant of Privileges.

ARTICLE XII:

CONFIDENTIALITY, IMMUNITY AND RELEASE

SECTION 12.1. SPECIAL DEFINITIONS

12.1-1 For the purposes of this Article, the following definitions shall apply.

a. "Information" means records of proceedings, minutes, records, reports, memoranda, statements, recommendations, dates, and other disclosures whether in written or oral form relating to any of the subject matter specified in Section 12.5.

b. "Representative" means the Board and any member or committee thereof, the Hospital, the CEO and other Hospital employees, the Staff organization and any appointee, member, officer, committee thereof, and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

c. "Third Parties" means both individuals and organizations providing Information to any Representative.

SECTION 12.2. AUTHORIZATIONS AND CONDITIONS

12.2-1 By applying for Medical Staff appointment and/or Clinical Privileges or by exercising his/her appointment/Clinical Privileges within this Hospital, a Practitioner:

a. Authorizes Representatives to solicit, gather, collect, provide and act upon Information bearing on his or her professional ability and qualifications.

b. Agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative who acts in accordance with the provisions of this Article.

c. Acknowledges that the provisions of this Article are express conditions to the application for, or acceptance of, Staff membership, or exercise of Clinical Privileges at Hospital.

SECTION 12.3. CONFIDENTIALITY OF INFORMATION

12.3-1 Information with respect to any Practitioner submitted, collected or prepared by any Representative of this Hospital or any other health care facility or organization or medical staff for the purpose of:

a. evaluating, monitoring, or improving the quality, appropriateness and efficiency of patient care;

b. evaluating the qualifications, competence, and performance of a Practitioner or acting upon matters relating to corrective action;

c. reducing morbidity or mortality;

d. contributing to teaching or clinical research

e. determining that health care services are professionally indicated and performed in compliance with applicable standards of care; or,

f. establishing and enforcing guidelines to help keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential.

12.3-2 Such Information shall not be disclosed or disseminated to anyone other than a Representative or other health care facility or organization of health professionals engaged in an official, authorized activity for which the Information is needed, nor be used in any way except as provided in these Bylaws, or as otherwise required by law.

12.3-3 Such confidentiality shall also extend to Information of like kind that may be provided to/by Third Parties. This Information shall not become part of any particular patient's record.

12.3-4 It is expressly acknowledged by each Practitioner that violation of the confidentiality provisions provided herein is grounds for immediate and permanent revocation of Medical Staff appointment and Privileges.

SECTION 12.4. RELEASE FROM LIABILITY

12.4-1 Submission of an application for Medical Staff appointment and/or Privileges and/or the exercise his/her appointment/Privileges at the Hospital constitutes a Practitioner's express release of liability of the following:

a. For Action Taken:

No Representative or Third Party, as applicable, shall be liable to a Practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as a Representative or

Third Party provided that such Representative or Third Party does not act on the basis of false Information knowing such Information to be false.

b. For Gathering/Providing Information:

No Representative or Third Party shall be liable to a Practitioner for damages or other relief by reason of gathering or providing Information, including otherwise confidential or privileged Information, for purposes of completing or updating an application for Privileges, provided that such Representative or Third Party does not act on the basis of false Information knowing it to be false.

SECTION 12.5. ACTIVITIES AND INFORMATION COVERED

12.5-1 Activities:

The confidentiality provided and releases required by this Article shall apply to all Information in connection with this Hospital's or any other educational or health-related institution's or organization's activities concerning, but not limited to:

a. Applications for appointment and Clinical Privileges.

b. Periodic reappraisals for reappointment and re-grant of Clinical Privileges.

c. Focused and Ongoing Professional Practice Evaluations.

d. Professional Review action.

e. Hearings and appellate review.

f. Quality Improvement Activities.

g. Utilization Reviews.

h. Other Hospital and committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

12.5-2 Information:

The Information referred to in this Article may relate to a Practitioner's professional qualifications, clinical ability, judgment, character, ability to perform services, professional ethics, ability to work cooperatively with others or any other matter that might directly or indirectly affect patient care or the efficient functioning of an institution or organization.

SECTION 12.6. RELEASES

Each Practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the requirements and intent of this Article, subject to applicable law. Execution of such releases shall not be deemed a prerequisite to the validity or effectiveness of this Article.

SECTION 12.7. CUMULATIVE EFFECT

Provisions in these Bylaws and in application forms relating to authorizations, releases, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

ARTICLE XIII:

GENERAL PROVISIONS

SECTION 13.1. COMMUNICATION

13.1-1 Communication between the Medical Staff, Hospital Administration, and the Board of Trustees shall be accomplished through (although not necessarily limited to) the following:

a. The Chief of Staff (or his designee during his absence) shall attend all regular Board of Trustees meetings.

b. Medical Director of the Hospital Quality Outcomes Committee shall attend MEC meetings.

c. The CEO (or his designee) shall attend Medical Staff Annual, Regular, Special and Committee meetings

SECTION 13.2. QUALITY IMPROVEMENT ACTIVITIES

The Medical Staff shall participate in Quality Improvement activities as required by the Board. Specific mechanisms to monitor and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated Clinical Privileges are specified in the Utilization Review Plan, Program for the Quality Improvement Activities of the Medical Staff and the Quality Improvement Plan.

SECTION 13.3. RULES AND REGULATIONS AND POLICIES

13.3-1 Rules and Regulations:

a. Medical Staff: Subject to approval by the Board, the Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Staff organizational activities as well as the level of practice required of each Practitioner or APP in the Hospital. Rules and Regulations will be adopted, amended or repealed at any regular or special Medical Staff meeting where a quorum of fifty percent (50%) of those eligible to vote are present, by an affirmative vote of sixty-seven (67%) by those present and eligible to vote, or as otherwise imposed by the Board. In the event that a quorum does not exist at a meeting at which action or amendment(s) of the Medical Staff Rules and Regulations are proposed, action may thereafter be taken by written ballot pursuant to the procedure set forth in Section 13.4-2 (a).

b. If the voting members of the organized medical staff propose to adopt a rule or regulation, or an amendment thereto, they must first communicate the proposal to the MEC. If the MEC proposes to adopt a rule or regulation, or an amendment thereto, it must first communicate the proposal to the medical staff.

c. In the event of a documented need for an urgent amendment to a Medical Staff rule or regulation necessary to comply with law or regulation, the MEC may provisionally adopt and the Board may provisionally approve such urgent amendment without prior notice to the Medical Staff. In such event, the Medical Staff shall thereafter be immediately notified by the MEC and shall be provided with the opportunity for retrospective review of, and comment on, the provisional amendment. If the Medical Staff agrees with the MEC's action, the provisional amendment shall stand. If the Medical Staff disagrees with the MEC's action, a meeting of the MEC and Medical Staff shall be held and, if necessary, a revised amendment shall be submitted to the Board for action.

d. Departments and Committees: Subject to the approval by the Board, each department and committee shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these Bylaws, the general rules and regulations of the Staff, or other policies of the Hospital or Medical Staff. A permanent file of current department and committee rules and regulations shall be maintained by the CEO.

e. The Rules and Regulations shall be reviewed at least every two (2) years and revised as appropriate.

13.3-2 Medical Staff Policies.

a. Subject to 13.4-2 (a) and (b) below, the Medical Staff delegates to the Medical Executive Committee the responsibility to adopt, amend, and repeal such Medical Staff policies as may be necessary to implement the general principles set forth in these Bylaws and for the proper conduct of the Medical Staff. Such Medical Staff policies may be adopted, amended, or repealed at any regular meeting of the Medical Executive Committee, without previous notice, by a majority affirmative vote of the MEC members eligible to vote. Adoption, amendment, or repeal of Medical Staff policies shall become effective when approved by the Board.

b. When the MEC adopts a Medical Staff policy or an amendment thereto, the MEC shall communicate such policy, or amendment, to the Medical Staff.

c. In the event the voting members of the Medical staff propose to adopt a Medical Staff policy, or an amendment thereto, the Medical Staff shall first communicate its proposal to the MEC.

SECTION 13.4. FORMULATION OF BYLAWS

13.4-1 Staff Responsibility and Authority:

The Staff may formulate, adopt, and recommend to the Board Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Medical Staff as provided in Section 13.4-2 and by the Board.

13.4-2 Methodology:

Medical Staff Bylaws may be adopted, amended, or repealed by the following combined action:

a. Staff:

1. The affirmative vote of sixty-seven (67%) of the Staff members eligible to vote on this matter who are present at a meeting at which a quorum exists, provided that the proposed Bylaws and/or alterations, accompanied the notice of the meeting.

2. In the event that a quorum does not exist at a meeting at which action or amendment(s) of the Medical Staff Bylaws or Medical Staff Rules and Regulations are proposed, action may thereafter be taken by written ballot. The written ballots shall be transmitted to all voting Appointees accompanied by the minutes of discussion, if any, concerning the proposed action or amendment(s). The ballot must be submitted to all voting Appointees at least two (2) weeks prior to the close of the voting period, to be established by the Medical Executive Committee. Ballots must be signed by the voting Appointees and signed ballots will be counted only if received by Medical Staff Services by the close of the two (2) week voting period. The total number of signed, returned ballots must at minimum equal a majority of Active Medical Staff voting Appointees. No action shall be effective except upon the affirmative vote of sixty-seven (67%) of the signed, returned ballots, assuming a quorum. The Medical Staff Services Manager or designee shall prepare and submit the written ballots to the voting Appointees, receive returned ballots, and transmit the returned ballots to the committee or Medical Staff, as applicable.

b. Board:

The Medical Staff Bylaws may be adopted, amended or repealed by the affirmative vote of two-thirds of the Board after receiving the recommendations of the Medical Staff. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws when necessary to provide for protection of patient welfare or when necessary to comply with accreditation standards or applicable law. However, should the Board act upon its own initiative as provided in this

paragraph, it shall consult with the Medical Staff at the next regular staff meeting (or at a special called meeting as provided in these bylaws), and shall advise the staff of the basis for its action in this regard.

c. Review:

The Medical Staff Bylaws shall be reviewed at least every two (2) years and revised as appropriate.

d. Conflict:

The Board, with input from the Medical Staff, shall work to ensure consistency between the Hospital governing documents and the Medical Staff Bylaws, policies and rules and regulations, and compliance with applicable law and regulations. However, in the event of conflict between the Medical Staff Bylaws, policies or rules and regulations, and the Hospital governing documents, the Hospital governing documents shall control.

e. Minor Technical Amendments:

The MEC shall have the power to adopt such amendments to the Bylaws and Rules and Regulations, as are, in its judgment, minor technical or editorial modifications or clarifications, such as: renumbering; corrections to punctuation, spelling, or other errors of grammar or expression; correcting inaccurate cross-references, pagination or headings; or to reflect changes in names of committees or officers. Such amendments shall be effective immediately and shall be permanent if not rejected by the Board within sixty (60) days of adoption by the MEC. The action to amend may be taken by motion acted upon in the same manner as any other motion before the MEC. After approval, such amendments shall be communicated in writing to the Board.

f. No Unilateral Amendment:

Neither the Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws.

g. Process

Amendments to these bylaws approved as set forth herein shall be documented by either:

1. Appending to these bylaws the approved amendment, which shall be dated and signed by the Chief of Staff, the CEO, the Chairperson of the Board of Trustees and approved by corporate legal counsel as to form; or

2. Restating the bylaws, incorporating the approved amendments and all prior approved amendments which have been appended to these bylaws since their last restatement, which restated bylaws shall be dated and signed by

the Chief of Staff, the CEO and the Chairperson of the Board of Trustees approved by corporate legal counsel as to form.

Each member of the Medical Staff shall have access to a copy of any amendments to these bylaws in a timely manner.

SECTION 13.5. REVISED MATERIAL

When significant changes are made to the Bylaws or the Rules and Regulations, the Medical Staff and other individuals with delineated Clinical Privileges shall be provided with revised text of the written materials.

SECTION 13.6. MEDICAL STAFF/MEC CONFLICT RESOLUTION

In the event of a conflict between the Medical Staff and MEC on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, a special meeting of the Medical Staff and MEC shall be convened to discuss the issue(s) of concern and resolution therefore. In the event that the issue(s) cannot be resolved to the mutual satisfaction of the parties, the matter shall be brought before the Medical Staff for vote subject to final review and action by the Board.

SECTION 13.7. APPOINTEE ACTION

Any Member of the Active Medical Staff in good standing may raise a challenge to a Medical Staff policy established by the MEC and approved by the Board. In order to raise such challenge, the Members of the Active Medical Staff must submit to the MEC a petition signed by not less than thirty percent (30%) of the Members of the Active Medical Staff in good standing. Upon receipt of the petition, the MEC shall either (a) provide the petitioner(s) with information clarifying the intent of such Medical Staff policy; and/or (b) schedule a meeting with the petitioner to discuss the issue. In the event that the issue cannot be resolved to the satisfaction of the petitioner(s), the matter shall be brought before the Medical Staff for vote, subject to final review and action by the Board.

ARTICLE XIV:APPENDIX "A" – FAIR HEARING PLAN

This Fair Hearing Plan is adopted in connection with the Medical Staff Bylaws and made a part thereof. The definitions and terminologies of the Bylaws also apply to the Fair Hearing Plan and proceedings hereunder.

SECTION 14.1. D E F I N I T I O N S

The following definitions, in addition to those stated in the Medical Staff Bylaws or herein, shall apply to the provisions of this Fair Hearing Plan.

1. "Appellate Review Body" means the group designated pursuant to this Plan to hear a request for Appellate Review that has been properly filed and pursued by the Practitioner.

2. "Corporation" shall mean Clinton Memorial Hospital.

3. "Hearing Committee" means the committee appointed pursuant to this Plan to hear a request for an evidentiary hearing that has been properly filed and pursued by a Practitioner.

4. "Parties" means the Practitioner who requested the hearing or Appellate Review and the body or bodies upon whose adverse action a hearing or Appellate Review request is predicated.

5. "Special Notice" means written notification sent by certified or registered mail, return receipt requested, or delivered by hand with a written acknowledgment of receipt.

ARTICLE I - INITIATION OF HEARING

1.1 RECOMMENDATION OR ACTIONS

A. The following recommendations or actions shall, if deemed adverse pursuant to Article I, Section 1.2 of this Fair Hearing Plan (Plan), entitle the Practitioner affected thereby to a hearing:

1. Denial of initial staff appointment;

2. Denial of reappointment;

3. Suspension of staff membership in excess of fourteen (14) days, except for automatic suspensions pursuant to the Medical Staff Bylaws;

4. Revocation of staff membership;

5. Denial of requested advancement of staff category if such denial materially limits the physician's exercise of privileges.

6. Reduction of staff category due to an adverse determination as to a Practitioner's competence or professional conduct;

7. Limitation of the right to admit patients;

8. Denial of an initial request for particular clinical privileges;

9. Reduction of clinical privileges for a period in excess of thirty (30) days;

10. Permanent suspension of clinical privileges;

11. Revocation of clinical privileges;

12. Terms of probation, if such terms of probation materially restrict the physician's exercise of privileges for more than thirty (30) days; and

13. Summary suspension of privileges or staff membership for a period in excess of fourteen (14) days.

B. Notwithstanding the provisions of Section 1.1(A) above, the following actions shall not be considered adverse and shall not constitute grounds for or entitle the Practitioner to a hearing:

1. An oral or written reprimand or warning.

2. The denial, termination, or suspension of temporary, locum tenens, disaster, telemedicine or emergency Privileges.

3. Imposition of a probationary period with retrospective or concurrent review of cases provided that such probationary period does not otherwise limit the Practitioner's ability to exercise his or her previously exercised Clinical Privileges.

4. Denial of appointment, reappointment or requested Privileges because the Practitioner failed to satisfy the basic qualifications or criteria of training, education, or experience established for appointment, reappointment or the granting of Privileges for a specific procedure or procedures.

5. Ineligibility for Medical Staff appointment or reappointment or the Privileges requested because a service has been closed or there exists an exclusive contract limiting the performance of the specialty with which the Practitioner is associated or the Privileges which the Practitioner has requested.

6. Termination by the Hospital of an employment agreement or services contract with a Practitioner unless the employment agreement or services contract provides otherwise.

7. Ineligibility for Medical Staff appointment or requested Privileges because of lack of facilities, equipment, or because the Hospital has elected not to perform, or does not provide, the service which the Practitioner intends to provide or the procedure for which Privileges are sought.

8. Automatic suspension or termination of Medical Staff appointment or Clinical Privileges.

9. A voluntary decision not to exercise Privileges, to relinquish Privileges, or to resign Medical Staff appointment.

10. Suspension of any or all Privileges or of Medical Staff appointment, for not more than fourteen (14) days.

11. The grant of Privileges or appointment to the Medical Staff for a period shorter than the maximum permitted length.

12. The MEC requiring that a Practitioner submits to a physical or cognitive evaluation.

13. Any other action which does not relate to the competence or professional conduct of a Practitioner.

1.2 WHEN DEEMED ADVERSE

A recommendation or action listed in Article I, Section 1.1(A) of this Plan shall be deemed adverse only if it is based upon competence or professional conduct, is Practitioner-specific and has been:

(1) Recommended by the MEC; or

(2) Taken by the Board contrary to a favorable recommendation by the MEC under circumstances where no right to hearing existed; or

(3) Taken by the Board on its own initiative without prior recommendation by the MEC.

1.3 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A Practitioner against whom an adverse recommendation or action has been taken pursuant to Article I, Section 1.1(A) of this Plan shall promptly be given special notice of such action. Such notice shall:

(1) Advise the Practitioner of the basis for the action and his/her right to a hearing pursuant to the provisions of the Medical Staff Bylaws of this Plan;

(2) Specify that the Practitioner has thirty (30) days following the date of receipt of notice within which a request for a hearing must be submitted;

(3) State that failure to request a hearing within the specified time period shall constitute a waiver of rights to a hearing and to an Appellate Review of the matter;

(4) State that upon receipt of this hearing request, the Practitioner will be notified of the date, time and place of the hearing, the grounds upon which the adverse action is based, and a list of the witnesses expected to testify in support of the adverse action;

(5) Provide a summary of the Practitioner's rights at the hearing; and

(6) Inform the Practitioner if the recommended action may be reportable to the National Practitioner Data Bank and appropriate licensing agencies.

1.4 REQUEST FOR HEARING

A Practitioner shall have thirty (30) days following his/her receipt of a notice pursuant to Article I, Section 1.3 to file a written request for a hearing. Such request shall be delivered to the CEO either in person or by certified or registered mail.

1.5 WAIVER BY FAILURE TO REQUEST A HEARING

A Practitioner who fails to request a hearing within the time and in the manner specified waives any right to such hearing and to any Appellate Review to which he/she might otherwise have been entitled. Such waiver in connection with:

(1) An adverse recommendation or action by the Board, CEO or their designees, shall constitute acceptance of that recommendation or action. (hereinafter, references to decisions by these entities or individuals shall be designated as decisions or actions of the Board); and

(2) An adverse recommendation by the MEC or its designee shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Board. The Board shall consider the MEC's recommendation at its next regular meeting following the waiver. In its deliberations, the Board shall review all relevant information and material considered by the MEC and may consider all other relevant information received from any source. The Board's action on the matter shall constitute a final decision of the Board. The CEO shall promptly send the Practitioner special notice informing him/her of each action taken pursuant to this Article I, Section 1.5(2) and shall notify the Chief of Staff and the MEC of each such action.

ARTICLE II - HEARING PREREQUISITES

2.1 NOTICE OF TIME & PLACE FOR HEARING

Upon receipt of a timely request for hearing, the CEO shall deliver such request to the Chief of Staff or to the Board, depending on whose recommendation or action prompted the request for hearing. The CEO shall send the Practitioner special notice of the time, place, and date of the hearing. The hearing date shall not be less than thirty (30) nor more than ninety (90) days from the date of receipt of the request for hearing; provided, however, that a hearing for a Practitioner who is under suspension then in effect shall, at the Practitioner's request, be held as soon as arrangements for it reasonably may be made, but not later than thirty (30) days from the date of receipt of the request for hearing.

2.2 STATEMENT OF ISSUES & EVENTS

The notice of hearing required by Article II, Section 2.1 shall contain a concise statement of the Practitioner's alleged act or omissions, and a list by number of specific or representative patient records in question and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing. The notice shall further contain a list of witnesses expected to testify in support of the adverse recommendation or action.

2.3 PRACTITIONER'S RESPONSE

Within ten (10) days of receipt of the notice of hearing under Section 2.2, the affected Practitioner shall deliver, by special notice, a list of witnesses expected to testify on his/her behalf at the due process hearing.

2.4 EXAMINATION OF DOCUMENTS

The Practitioner may request that he/she be allowed to examine any documents to be introduced in support of the adverse recommendation. The body initiating the adverse action shall also be entitled to examine all documents expected to be produced by the Practitioner at the hearing. The parties shall exchange such documents at a mutually agreeable time at least ten (10) days prior to the hearing. Copies of any patient charts, which form the basis for the adverse action shall be made available to the Practitioner, at his/her expense, within a reasonable time after a request is made for same.

2.5 APPOINTMENT OF HEARING COMMITTEE

2.5(a) By Medical Staff

A hearing occasioned by an adverse MEC recommendation pursuant to Article I, Section 1.2(1) shall be conducted by a Hearing Committee appointed by the Chief of Staff and

composed of three (3) members of the Medical Staff. None of the Hearing Committee members shall be partners, associates, relatives or in direct economic competition with the affected individual. Should the Chief of Staff find it impossible to appoint a committee meeting the above requirements or otherwise find good cause to utilize physicians outside the staff, he/she may, upon approval by the CEO, appoint an independent panel of three (3) physicians meeting all requirements of this section with the exception of Medical Staff membership.

The affected individual shall have ten (10) days after notice of the appointment of the Hearing Committee members to object and identify in writing, any conflict of interest with any Hearing Committee members which the affected individual believes should disqualify the Hearing Committee member(s) from service. The failure of the affected individual to object and identify any conflict of interest as stated above shall constitute a waiver of any such right. Within seven (7) days of the receipt of the objections, the Chief of Staff shall determine whether such grounds asserted by the affected individual are sufficient for disqualification. If a determination is made that a disqualification is appropriate, a replacement shall be appointed within seven (7) days of the determination. The Chief of Staff shall advise the affected individual accordingly. One (1) of the members so appointed shall be designated as Chairperson.

2.5(b) <u>By Board</u>

A hearing occasioned by an adverse action of the Board pursuant to Article I, Section 1.2(2) or 1.2(3) shall be conducted by a Hearing Committee appointed by the Chairperson of the Board and composed of three (3) people. At least one (1) Active Medical Staff member shall be included on this committee. Should the Board Chairperson find it impossible to appoint a committee meeting the above requirements or otherwise find good cause to utilize a physician outside the staff, he/she may, upon approval by the CEO, appoint a physician meeting all requirements of this section with the exception of Active Medical Staff membership. One (1) of the appointees to the committee shall be designated as Chairperson. If the matter concerns or arises from issues regarding a physician's clinical competence or performance, the Hearing Committee must be composed of three (3) physicians who may or may not be members of the Hospital's Medical Staff.

The affected individual shall have ten (10) days after notice of the appointment of the Hearing Committee members to object and identify in writing, any conflict of interest with any Hearing Committee members which the affected individual believes should disqualify the Hearing Committee member(s) from service. The failure of the affected individual to object and identify any conflict of interest as stated above shall constitute a waiver of any such right. Within seven (7) days of the receipt of the objections, the Board Chairman shall determine whether such grounds asserted by the affected individual are sufficient for disqualification. If a determination is made that a disqualification is appropriate, a replacement shall be appointed within seven (7) days of the determination. The Board Chairman shall advise the affected individual accordingly. One (1) of the members so appointed shall be designated as Chairperson.

2.5(c) <u>Service on Hearing Committee</u>

A Medical Staff or Board member shall not be disqualified from serving on a Hearing Committee solely because he/she has participated in investigating the action or matter at issue.

ARTICLE III - HEARING PROCEDURE

3.1 PERSONAL PRESENCE

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Article I, Section 1.5.

3.2 PRESIDING OFFICER

The Hearing Officer, if one is appointed pursuant to Article VIII, Section 8.1, shall be the Presiding Officer. The Presiding Officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/She shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

3.3 REPRESENTATION

The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney, a member of the Medical Staff in good standing, a member of his/her local professional society, or other individual of the physician's choice. The MEC or the Board, depending on whose recommendation or action prompted the hearing, shall appoint an individual to present the facts in support of its adverse recommendation or action, and to examine the witnesses. Representation of either party by an attorney at law shall be governed by the provisions of Article VIII, Section 8.2 of this Plan.

3.4 RIGHTS OF THE PARTIES

During a hearing, each of the parties shall have the right to:

(1) Call and examine witnesses;

(2) Present evidence determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law;

(3) Cross-examine any witness on any matter relevant to the issues;

(4) Impeach any witness;

(5) Rebut any evidence;

(6) Have a record made of the proceeding, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof; and

(7) Submit a written statement at the close of the hearing.

If any Practitioner who requested the hearing does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

3.5 PROCEDURE & EVIDENCE

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence although these rules may be considered in determining the weight of the evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of admissibility of such evidence in a court of law. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the hearing record. The Presiding Officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him/her and entitled to notarize documents in the state where the hearing is held.

3.6 OFFICIAL NOTICE

In reaching a decision, the Hearing Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical, medical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the state where the hearing is held. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the record of the hearing. Any party shall be given opportunity on timely motion, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Committee.

3.7 BURDEN OF PROOF

(1) When a hearing relates to the matters listed in Article I, Sections 1.1(A)(1), 1.1.(A)(5) or 1.1(A)(8), the Practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any substantial factual basis or that the action is arbitrary, capricious or impermissibly discriminatory.

(2) For the other matters listed in Article I, Section 1.1(A), the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof; but the Practitioner thereafter shall be responsible for supporting his/her challenge to the adverse recommendation or action by a preponderance of the evidence that the grounds therefore lack any substantial factual basis or that the action is arbitrary, capricious or impermissibly discriminatory. The standards of proof set forth herein shall apply and be binding upon the Hearing Committee and on any subsequent review or appeal.

3.8 RECORD OF HEARING

A record of the hearing shall be kept that is of sufficient accuracy to permit an informed and valid judgment to be made by any group that later may be called upon to review the record and render a recommendation or decision in the matter. The method of recording the hearing shall be by use of a court reporter.

3.9 POSTPONEMENT

Request for postponement of a hearing shall be granted by agreement between the parties or the Hearing Committee only upon a showing of good cause and only if the request therefore is made as soon as is reasonably practical.

3.10 PRESENCE OF HEARING COMMITTEE MEMBERS & VOTING

A majority of the Hearing Committee must be present throughout the hearing and deliberations. If a committee member is absent from a substantial portion of the proceedings, he/she shall not be permitted to participate in the deliberations of the decision.

3.11 RECESSES & ADJOURNMENT

The Hearing Committee may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence for consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties and without a record of the deliberation being made. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

3.12 HEARING COMMITTEE PARTICIPATION

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

ARTICLE IV - HEARING COMMITTEE REPORT & FURTHER ACTION

4.1 HEARING COMMITTEE REPORT

Within fourteen (14) days after the transcript of the proceedings has been delivered to the proper officer of the hearing, or if no transcript is ordered, then thirty (30) days after the hearing ends, the Hearing Committee shall make a written report of its findings and recommendations in the matter. The Hearing Committee shall forward the same, together with the hearing record and all other documentation considered by it, to the Board or the MEC, for action consistent with Section 4.2 below. All findings and recommendations by the Hearing Committee shall be supported by reference to the hearing record and the other documentation considered by it. Recommendations must be made by a majority vote of the members and the committee may only consider the specific recommendations or actions of the Board or MEC. The Practitioner who requested the hearing shall be entitled to receive the written recommendations of the Hearing Committee, including a statement of the basis for the recommendation.

4.2 ACTION ON HEARING COMMITTEE REPORT

If the MEC initiated the action, and the Hearing Committee's report alters, amends or modifies the MEC's recommendation, the MEC shall take action on the Hearing Committee report no later than twenty-eight (28) days after receipt of same, and prior to any appeal by the Practitioner. If the MEC initiated the action and the Hearing Committee has not altered, amended or modified the MEC recommendation, or if the Board initiated the action and the action remains adverse to the Practitioner, the Practitioner shall be given notice of the right to appeal pursuant to Section 4.3(c) prior to final action by the Board. If the Board initiated the action, and the Hearing Committee recommendation is favorable to the Practitioner, the Board shall take action on the Hearing Committee's report no later than twenty-eight (28) days from receipt of same.

4.3 NOTICE & EFFECT OF RESULT

4.3(a) Notice

The CEO shall promptly send a copy of the result to the Practitioner by special notice, including a statement of the basis for the decision.

4.3(b) Effect of Favorable Result

(1) Adopted by the Board: If the Board's result is favorable to the Practitioner, such result shall become the final decision of the Board and the matter shall be considered finally closed.

(2) Adopted by the Medical Executive Committee: If the MEC's result is favorable to the Practitioner, the CEO shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereon by adopting or rejecting the MEC's result in whole or in part, or by referring the

matter back to the MEC for further consideration. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, and consultation with the Corporation as necessary, the Board shall take final action. The CEO shall promptly send the Practitioner special notice informing him/her of each action taken pursuant to this Article IV, Section 4.3(b)(2). Favorable action shall become the final decision of the Board, and the matter shall be considered finally closed.

4.3(c) Effect of Adverse Result

At the conclusion of the process set forth in Section 4.2, if the result continues to be adverse to the Practitioner in any of the respects listed in Article I, Section 1.1(A) of this Plan, the Practitioner shall be informed, by special notice of his/her right to request an Appellate Review as provided in Article V, Section 5.1 of this Plan. Said notice shall be delivered to the Practitioner no later than fourteen (14) days from the MEC action, or Hearing Committee report, as appropriate under Section 4.2.

ARTICLE V - INITIAL & PREREQUISITES OF APPELLATE REVIEW

5.1 REQUEST FOR APPELLATE REVIEW

A Practitioner shall have fourteen (14) days following his/her receipt of a notice pursuant to Article IV, Section 4.3(c) to file a written request for an Appellate Review. Such request shall be delivered to the CEO either in person or by certified or registered mail and may include a request for a copy of the report and record of the Hearing Committee and all other material, favorable or unfavorable, if not previously forwarded, that was considered in reaching the adverse result.

5.2 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW

A Practitioner who fails to request an Appellate Review within the time and manner specified in Article V, Section 5.1 shall be deemed to have waived any right to such review.

Such waiver shall have the same force and effect as that provided in Article I, Section 1.5 of this Plan.

5.3 NOTICE OF TIME & PLACE FOR APPELLATE REVIEW

Upon receipt of a timely request for Appellate Review, the CEO shall deliver such request to the Board. As soon as practicable, the Board shall schedule and arrange for an Appellate Review which shall be not less than twenty-one (21) days from the date of receipt of the Appellate Review request; provided, however, that an Appellate Review for a Practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may reasonably be made, but not later than twenty-one (21) days from the date of receipt of the request for review. At least ten (10) days prior to the Appellate Review, the CEO shall send the Practitioner special notice of the time, place and date of the review. The time for the Appellate Review may be extended by the Appellate Review Body for good cause and if the request therefore is made as soon as reasonably practical.

5.4 APPELLATE REVIEW BODY

The Appellate Review Body shall be composed of the Board of Trustees or a committee of at least three (3) members of the Board of Trustees. One (1) of its members shall be designated as the Chairperson of the committee.

ARTICLE VI - APPELLATE REVIEW PROCEDURE

6.1 NATURE OF PROCEEDINGS

The proceedings of the Appellate Review Body shall be in the nature of an Appellate Review based upon the record of the hearing before the Hearing Committee, and the committee's report, and all subsequent results and actions thereon. The Appellate Review Body also shall consider the written statements, if any, submitted pursuant to Article VI, Section 6.2 of this Plan and such other material as may be presented and accepted under Article VI, Sections 6.4 and 6.5 of this Plan. The Appellate Review Body shall apply the standards of proof set forth in Article III, Section 3.7.

6.2 WRITTEN STATEMENTS

The Practitioner seeking the review shall submit a written statement detailing the findings of fact, conclusions and procedural matters with which he/she disagrees, and his/her reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, but may not raise new factual matters not presented at the hearing. The statement shall be submitted to the Appellate Review Body through the CEO at least seven (7) days prior to the scheduled date of the Appellate Review, except if such time limit is waived by the Appellate Body. A written statement in reply may be submitted by the MEC or by the Board, and if submitted, the CEO shall provide a copy thereof to the Practitioner at least three (3) days prior to the scheduled date of the Appellate Review.

6.3 PRESIDING OFFICER

The Chairperson of the Appellate Review Body shall be the Presiding Officer. He/She shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

6.4 ORAL STATEMENT

The Appellate Review Body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements supporting their positions. If the Appellate Review Body allows one (1) of the parties to make an oral statement, the other party shall be allowed to do so. Any party or representative so appearing shall be required to answer questions put to him/her by any member of the Appellate Review Body.

6.5 CONSIDERATION OF NEW OR ADDITIONAL MATTERS

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report, and not otherwise reflected in the record shall not be introduced at the Appellate Review, except by leave of the Appellate Review Body. The Appellate Review Body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted,

following establishment of good cause by the party requesting the consideration of such matter or evidence as to why it was not presented earlier. If such additional evidence is considered, it shall be subject to cross examination and rebuttal.

6.6 PRESENCE OF MEMBERS & VOTING

A majority of the Appellate Review Body must be present throughout the review and deliberations. If a member of the Appellate Review Body is absent from a substantial portion of the proceedings, he/she shall not be permitted to participate in the deliberations or the decision.

6.7 RECESSES & ADJOURNMENT

The Appellate Review Body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of consultation. Upon the conclusion of oral statements, if allowed, the Appellate Review shall be closed. The Appellate Review Body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the Appellate Review shall be declared finally adjourned.

6.8 ACTIONS TAKEN

The Appellate Review Body may affirm, modify or reverse the adverse result or action taken by the MEC or by the Board pursuant to Article IV, Section 4.2 or Section 4.3(b)(2) or, in its discretion, may refer the matter back to the Hearing Committee for further review and recommendation to be returned to it within fourteen (14) days and in accordance with its instructions. Within seven (7) days after such receipt of such recommendations after referral, the Appellate Review Body shall make its final determination.

6.9 CONCLUSION

The Appellate Review shall not be deemed to be concluded until all of the procedural steps provided herein have been completed or waived.

ARTICLE VII - FINAL DECISION OF THE BOARD

No later than twenty-eight (28) days after receipt of the recommendation of the Appellate Review Body, or twenty-eight (28) days after waiver of Appellate Review, the Board shall consider the same and affirm, modify or reverse the recommendation. When a matter of Hospital policy or potential liability is presented, the Board shall consult with Corporation prior to taking action. The decision made by the full Board after receipt of the written recommendation from the Appellate Review Body will be deemed final, subject to no further appeal under the provisions of this Fair Hearing Plan. The action of the Board will be promptly communicated to the Practitioner in writing by certified mail.

ARTICLE VIII - GENERAL PROVISIONS

8.1 HEARING OFFICER APPOINTED & DUTIES

The use of a Hearing Officer to preside at an evidentiary hearing is optional. The use and appointment of such an officer shall be determined by the CEO in consultation with the Chief of Staff. A Hearing Officer may or may not be an attorney at law but must be experienced in conducting hearings. He/She shall act as the Presiding Officer of the hearing and participate in the deliberations.

8.2 ATTORNEYS

If the affected Practitioner desires to be represented by an attorney at any hearing or any Appellate Review appearance pursuant to Article VI, Section 6.4, his/her initial request for the hearing should state his/her wish to be so represented at either or both such proceedings in the event they are held. The MEC or the Board may be represented by an attorney.

8.3 NUMBER OF HEARINGS & REVIEWS

Notwithstanding any other provision of the Medical Staff Bylaws or of this Plan, no Practitioner shall be entitled as of right to more than one (1) evidentiary hearing and Appellate Review with respect to an adverse recommendation or action.

8.4 RELEASE

By requesting a hearing or Appellate Review under this Fair Hearing Plan, a Practitioner agrees to be bound by the provisions of the Medical Staff Bylaws relating to immunity from liability in all matters relating thereto.

8.5 WAIVER

If any time after receipt of special notice of an adverse recommendation, action or result, a Practitioner fails to make a required request of appearance or otherwise fails to comply with this Fair Hearing Plan or to proceed with the matter, he/she shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the Medical Staff Bylaws then in effect or under this Fair Hearing Plan with respect to the matter involved.

ARTICLE IX – AMENDMENT OF FAIR HEARING PLAN

This Appendix A shall only be amended in accordance with Article XIII of the Medical Staff Bylaws.

ADOPTED BY THE MEDICAL STAFF ON May 6, 2024

Rajiv Patel, M.D.
Chief of Staff

David Cohen, MD
Director of Medicine

Rachel Lovano, MD
Director of Surgery

APPROVED BY THE BOARD OF TRUSTEES ON July 24, 2024

Philip Aschi, DO
Chairman

APPROVED AS TO FORM:

By: Jeffrey D. Mosley
Legal counsel for RCHP-Wilmington, LLC

8-14-24
Date:

APPROVED:

By: ~~Group President~~ CEO Rob Jay

8/15/2024
Date: