Insight Surgical Hospital

Medical Staff Bylaws

September 2021

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PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of medical care, treatment and services delivered by all practitioners with clinical privileges in the Hospital; is responsible for the ongoing evaluation of the competency of all practitioners with clinical privileges and delineating the scope of clinical privileges that are granted to all practitioners with clinical privileges; is responsible for providing leadership in performance improvement activities within the Hospital; must create a set of Bylaws that define the Medical Staff's role within the Hospital and responsibilities in the oversight of care treatment and services; and must accept and discharge these responsibilities, subject to the ultimate authority of the Governing Board, and that the cooperative efforts of the Medical Staff, the Manager, and the Governing Board are necessary to fulfill the Hospital's obligations to its patients and their families, and the Physicians practicing in the Hospital hereby organize themselves in conformity with these Medical Staff Bylaws and Rules and Regulations. The Medical Staff is responsible to assure the Medical Staff Bylaws, Rules and Regulations, and self-governance is congruent with the Hospital's mission, vision and values.

ARTICLE I DEFINITIONS

ADVANCE PRACTICE PROFESSIONAL or **APP** are non-physician providers who may practice under the supervision of a physician, or sometimes independently as allowed by law, and are responsible for the examination and treatment of patients, having prescriptive authority. These practitioners are Nurse Practitioners (NP), Physician Assistants (PA), Chiropractors (D.C), RN Surgical Assists, and Certified Nurse Anesthetists (CRNA).

AUTHORIZED REPRESENTATIVE or **HOSPITAL'S AUTHORIZED REPRESENTATIVE** means the individual designated by the Hospital and approved by the Governing Board to provide information to and request information from the National Practitioner Data Bank according to the terms of these Bylaws.

BYLAWS shall mean the Bylaws of the Medical Staff as approved by the Governing Board, which may be amended from time to time.

CHIEF EXECUTIVE OFFICER (CEO) or Chief Operating Officer (COO) means the individual appointed by the Governing Board in accordance with the Agreement to act on its behalf in the overall management of the Hospital.

CHIEF OF STAFF or **CHIEF OF THE MEDICAL STAFF** means the chief officer of the Medical Staff elected by Members of the Medical Staff.

CLINICAL PRIVILEGES or **PRIVILEGES** means the permission granted to Medical Staff Members to provide patient care and to access those Hospital resources (including equipment, facilities and Hospital personnel), which are necessary to effectively exercise those Privileges.

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.

FAIR HEARING or HEARING means the procedure and safeguards set forth in Article IX.

FEDERAL HEALTH CARE PROGRAM means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (with the exception of the Federal Employees Health Benefits Programs). The most significant Federal health care programs are Medicare, Medicaid, Tricare/Champus and the Veterans programs.

GOOD STANDING means the Medical Staff Member has met committee requirements during the previous Medical Staff year, is not in arrears in dues payment, is not under automatic or summary suspension and has had three (3) or less medical records suspensions during the previous Medical Staff year.

GOVERNING BOARD means the Board of Directors of the Hospital.

HOSPITAL means Southeast Insight Surgical Hospital, LLC d/b/a Insight Surgical Hospital

HOSPITAL REPRESENTATIVE includes the Insight Surgical Hospital's Governing Board, its directors and committees; the Chief of Staff, the Hospital's CEO, all Medical Staff Members, and committees which have responsibility for collecting or evaluating a Practitioner's, Member's or APP's credentials or acting upon a Practitioner's, Member's or APP's applications; and any authorized representative of any of the foregoing.

INDEPENDENT LICENSED PRACTITIONER or PRACTITIONER means any appropriately licensed physician, dentist or podiatrist allowed by State law to practice independently, and without direct supervision of another Practitioner, applying for or exercising Clinical Privileges in this Hospital.

INELIGIBLE PERSON means any individual who: (1) is currently excluded, suspended, debarred or ineligible to participate in any federal health care program; or (2) has been convicted of a criminal offense related to the provision of healthcare items or services and has not been reinstated in a Federal health care program after a period of exclusion, suspension, debarment or ineligibility.

INVESTIGATION means a process specifically instigated by the MEC or Governing Board to determine the validity of a concern or complaint raised against a Member or APP.

MANAGER means Insight Surgical Hospital of Michigan, Inc., jointly owned by JSCE Holdings, LLC, a Michigan limited liability company and IINN Holdings, Inc., a Michigan corporation, whose address is 4800 S. Saginaw Street, Flint, MI 48507.

MEDICAL EXECUTIVE COMMITTEE or **MEC** means the executive committee of the Medical Staff that shall constitute the governing body of the Medical Staff as described in these Bylaws.

MEDICAL STAFF or **STAFF** means those Practitioners who have been granted appointment as Members of the Medical Staff pursuant to the terms of these Bylaws.

MEDICAL STAFF COORDINATOR means the Hospital designee for maintenance of Medical Staff records.

MEDICAL STAFF YEAR means the period from January 1 to December 31.

MEMBER means, unless otherwise expressly limited, any Practitioner holding a current license to practice within the scope of that license who has been appointed by the Governing Board to the membership of the Medical Staff.

PHYSICIAN means an individual as defined in the Centers for Medicare and Medicaid Services in Sec. 1861. [42 U.S.C. 1395x] of the Social Security Act.

PREROGATIVE means a participatory right granted, by virtue of Staff category or otherwise, to a Member and exercisable subject to the conditions imposed in these Bylaws and in other Hospital and Medical Staff policies approved by the Governing Board.

PROFESSIONALLY ASSOCIATED means affiliated by means of participation as a partner in, current shareholder, member of, or employee of, a medical practice entity, including, but not limited to, a partnership, professional corporation, or medical group practice.

RULES AND REGULATIONS means the rules and regulations of the Medical Staff, including its departments and divisions, if any, approved by the MEC and the Governing Board.

SPECIAL NOTICE means written notification sent by certified mail, return receipt requested, hand delivered or overnight mail that requires a signature to the addressee.

ARTICLE II NAME

2.1 NAME

The name of this organization shall be the Medical Staff of Insight Surgical Hospital

ARTICLE III PURPOSES AND RESPONSIBILITIES

3.1 PURPOSES

The purposes of the Medical Staff are:

(a) To be the formal organizational structure through which the benefits of membership on the Medical Staff may be obtained by Practitioners and the obligations of Medical Staff membership may be fulfilled.

(b) To provide oversight of patient care, treatment and services furnished by Members, APPs and provide for a uniform quality of patient care, treatment, and services, to provide leadership for performance improvement activities and patient safety and to report to the Governing Board.

(c) To serve as a primary means of accountability to the Governing Board by all practitioners who are granted clinical privileges through the appropriate delineation of Clinical Privileges, and to ensure a high level of competence and efficiency of all practitioners with clinical privileges through an ongoing review and evaluation of each performance with fair hearing, appeal and corrective action for Members when necessary.

(d) To initiate, maintain and amend Bylaws and Rules and Regulations for self-governance of the Medical Staff and to provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff and communicated through the Chief of the Medical Staff, the MEC or directly by the Medical Staff to the Governing Board.

(e) To monitor and enforce compliance with the Bylaws, Rules and Regulations, other Medical Staff policies, Hospital policies and procedures, applicable accreditation requirements, and applicable federal, State and local laws and regulations.

(f) To provide continuing education for all practitioners with clinical privileges that will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skills.

3.2 RESPONSIBILITIES

The Medical Staff shall be responsible for the following:

3.2-1 Quality and Appropriateness Accountability

Accounting for the quality and appropriateness of patient care rendered by all practitioners with clinical privileges authorized to practice in the Hospital through the following measures:

(a) A credentials program, including mechanisms for appointment and reappointment and the delineation of Clinical Privileges to be exercised or of specified services to be performed based on verified credentials and current demonstrated performance of the applicant, or practitioner with clinical privileges.

(b) An ongoing utilization review program to evaluate medical and health services based upon patient specific determinations of individual medical needs, required level of care and current existing regulatory requirements.

(c) An organizational structure that allows continuous monitoring and evaluation of patient care practices and assuring that the management of patient care is the responsibility of a physician Member with appropriate Clinical Privileges.

(d) Providing a leadership role and participating in Hospital performance improvement to include process measurement, quality assessment, and improvement of patient care processes as related to:

(ii) Medical assessment and treatment of patients;

(iii) Use of information in adverse privileging decisions;

(iv) Use of medications;

(v) Use of blood and blood components;

(vi) Operative and other invasive procedures;

(vii) Appropriateness of clinical practice patterns;

(viii) Significant departures from established patterns of clinical practice;

(ix) The use of developed criteria for autopsies;

(x) Sentinel event data;

(xi) Patient safety data;

(xii) Accurate, timely, and legible completion of medical records;

(xii) Coordination of care among all practitioners with clinical privileges and Hospital personnel as relevant to the care, treatment and services of an individual patient;

(xiii) Education of patients and families;

(xiv) Patient Satisfaction

(xv) Findings of the assessment process that are relevant to the performance of a practitioner with clinical privileges.

(e) Performing history and physical examinations ("H&P") in accordance with these Bylaws.

(f) Reviewing and modifying, as necessary, clinical practice guidelines.

3.2-2 Responsibilities to the Governing Board

Medical Staff responsibilities to the Governing Board are as follows:

(a) Consulting with and making recommendations to the Governing Board including actions with respect to appointments, reappointments, Staff category, Clinical Privileges, and corrective action;

(b) Accounting to the Governing Board for the quality, appropriateness and efficiency of patient care rendered to patients in the Hospital through regular reports and recommendations concerning the implementation, operation and results of the performance improvement, quality and utilization management programs;

(c) Developing Medical Staff policies which define processes to grant authority to the MEC to act on behalf of the Medical Staff in regards to the development, change, and implementation of Medical Staff rules and regulations and Medical Staff policies; design and implementation of a process of supporting and reinforcing a productive working relationship between the Medical Staff and the Governing Board; addressing situations in which the Medical Staff does not believe the MEC is representing their views in regard to patient safety and quality of care with a method for dispute resolution; and designing a method for the Medical Staff to propose Bylaws, Rules and Regulations, and Medical Staff policies directly to the Governing Board;

(d) Working with Hospital administration and the Governing Board to define their shared and unique responsibilities and accountabilities;

(e) Initiating and pursuing corrective action with respect to all practitioners with clinical privileges when warranted using criteria approved by the Medical Staff and meeting national standards of practice.

(f) Developing, administering, and enforcing the Bylaws, the Rules and Regulations of the Medical Staff, other Medical Staff policies, other Hospital policies and procedures, accreditation requirements, and federal, State and local laws and regulations, including approving or disapproving amendments to the Bylaws and Rules and Regulations and selecting and removing Medical Staff officers.

3.2-3 Compliance with Medical Staff and Hospital Policies

Developing, administering, and seeking compliance with these Medical Staff Bylaws, the Rules and Regulations of the staff, and other Hospital policies.

3.2-4 Hospital Accreditation Needs

Actively cooperating with hospital accreditation activities and assisting the Hospital in maintaining accreditation.

3.2-5 Exercise of Authority

Exercising the authority granted by these Medical Staff Bylaws as necessary to adequately fulfill the foregoing responsibilities.

ARTICLE IV MEMBERSHIP

4.1 NATURE OF MEMBERSHIP

Membership on the Medical Staff of the Hospital is a privilege, which shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the Staff shall confer on the appointee or Member only such Clinical Privileges and Prerogatives as have been granted by the Governing Board in accordance with these Bylaws, and shall include Medical Staff category, and any service area assignments, if applicable. These Bylaws, in and of itself, shall not be construed in a manner as to create a contract, employment, property or liberty right, or interest in Privileges or the continuation of Privileges. An applicant or Member is neither an employee nor independent contractor of the Hospital unless such a relationship is established separately between the Hospital and such applicant or Member. In the event of any conflict between these Bylaws and a specific contract between a Member and the Hospital, the terms of the contract shall control.

4.2 QUALIFICATIONS FOR MEMBERSHIP

4.2-1 General Qualifications

Only Practitioners deemed to possess basic qualifications for membership in the Medical Staff and who provide a valid picture ID issued by a State of Federal agency may be granted membership on the Medical Staff. Practitioners may be granted membership, who:

(a) Document their (1) current licensure in the State, (2) adequate experience, education, and training, (3) current professional competence, (4) good clinical judgment and knowledge, and (5) current adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are

professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;

(b) Are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep confidential, as required by law, all information or records received in the Practitioner-patient relationship, and (4) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff;

(c) Maintain in force continuous and uninterrupted professional liability insurance in not less than the minimum amounts, if any, as from time to time may be determined by the Governing Board. If professional liability insurance is obtained on a claims-made basis, the Member shall be required to purchase tail insurance or its equivalent, as necessary, in order to prevent a lapse in coverage and shall provide evidence of such coverage to the Hospital;

(d) Verify that they are not currently an Ineligible Person and shall not become an Ineligible Person and shall specifically agree to provide to the Medical Staff with or without request, any new or updated information that is pertinent to the individual's licensure, professional qualifications, current DEA registration, or any question on the application form, including but not limited to any change in Ineligible Person status, any change in the sanctions imposed or recommended by the U.S. Department of Health and Human Services or any State;

(e) Disclose, in writing, to all patients the Practitioner refers to the Hospital at the time the referral is made, any ownership or investment interest in the Hospital that is held by the Practitioner or by an immediate family member of the Practitioner (defined as a husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, sister-in-law, or brother-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild).

(f) Document a history of previous professional liability claims, current claims and the final settlement or judgment rendered in each instance; and

(g) Notify the CEO or designee immediately upon receipt of notice of any professional liability claim or action pending against them regardless of the nature of such claim or action and its anticipated final outcome. A record of such claim or action and its ultimate outcome will be maintained in the Member's credentialing file.

4.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership in the Medical Staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical specialty board, or because such person had, or presently has, staff membership or privileges at another health care facility.

4.4 NONDISCRIMINATION

Appointments and Clinical Privileges shall not be denied on any basis that violates applicable law or facility policy.

4.5 HEALTH STATUS

The Practitioner will submit a written statement as to his/her physical and mental fitness to provide care associated with requested Privileges.

When the credentials committee, MEC, or Governing Board has reason to believe that the physical and/or mental health status of a Practitioner may be impaired, the Practitioner shall be required to submit to an evaluation of physical and/or mental health status by a practitioner designated by the MEC and as a prerequisite to the maintenance of Member's current Staff membership or the exercise previously granted of Clinical Privileges, or to further consideration of application for Medical Staff reappointment or for initial Medical Staff appointment.

4.6 RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

The responsibilities of each Member of the Medical Staff include:

(a) Providing patients with care that is at the level of quality meeting the professional standards of the Medical Staff of this Hospital;

(b) Abiding by the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Medical Staff and Hospital policies and procedures, accreditation requirements and federal, State and local laws and regulations;

(c) Discharging in a responsible and cooperative manner, such reasonable responsibilities and assignments imposed upon the Member by virtue of Medical Staff membership, including committee assignments;

(d) Promptly notifying the MEC of the revocation, suspension, or a lapse of Member's professional license or the imposition of terms of probation or limitation of practice by any state licensing agency; or loss or restriction, whether voluntary or involuntary, of Privileges at any hospital or other health care institution or of any adverse malpractice judgment or settlement or of the commencement of a formal investigation or the filing of charges, by the U.S. Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or any state; or the cancellation or restriction of Member's professional liability coverage or the revocation, suspension or voluntary relinquishment or lapse of member's DEA certification;

(e) Preparing and completing in timely fashion medical records for all the patients to whom the Member provides care in the Hospital;

(f) Abiding by the lawful ethical principles of the Member's professional association;

(g) Aiding in any Medical Staff approved educational programs of patients and families;

(h) Working cooperatively with members, nurses, Hospital administration and others;

(i) Making appropriate arrangements for coverage of that Member's patients as determined by the Medical Staff and refraining from delegating the responsibility for patient care to an inadequately qualified individual;

(j) Refusing to engage in improper inducements for patient referral;

(k) Participating in continuing education programs as determined by the Medical Staff;

(l) Participating in consultation panels as may be required by the Medical Staff or the Hospital;

(m) Discharging such other Staff obligations as may be established from time to time by the Medical Staff or MEC; and

(n) Providing information to the Medical Staff regarding any matter under an investigation pursuant to paragraph 8.1-3, and those, which are the subject of a hearing pursuant to Article IX. Participating in peer review or the review of the quality of professional services provided as may be requested or required by the Medical Staff. This includes cooperating in any review of a Member's or one's own credentials, qualifications or compliance with these Bylaws, and refraining from directly or indirectly interfering, obstructing or hindering any such review, whether by threat of harm or liability, by withholding information, by refusing to serve or participate in assigned responsibilities or otherwise.

(o) Arrive to scheduled surgical cases on time.

4.7 HARASSMENT PROHIBITED

Harassment by a Member against any individual (e.g., against another Member, Hospital employee or patient) on the basis of age, race, religion, color, national origin, ancestry, disability, marital status, sex or sexual orientation or any other protected class shall not be tolerated.

All allegations of harassment shall be immediately investigated by the Governing Board, MEC or Manager, and may result in appropriate corrective action in accord with these Bylaws, ranging from reprimand up to and including termination of Medical Staff Privileges or membership, as warranted by the facts.

ARTICLE V CATEGORIES OF MEMBERSHIP

5.1 CATEGORIES

The Medical Staff shall be divided into Active, Active Provisional, Consulting, and Courtesy-Staff categories.

5.2 ACTIVE STAFF

5.2-1 Qualifications

The Staff shall consist of Members each of whom:

(a) Meets the basic qualifications set forth in Section 4.2-1;

(b) Have offices or residences that, in the opinion of the MEC, are located close enough to the Hospital to provide appropriate continuity of quality care;

(c) Regularly care for patients in this Hospital or are regularly involved in Medical Staff functions, as determined by the MEC.

(d) Active medical staff practitioners are required to complete a minimum of twelve (12) surgical cases within a two-year period.

(e) Except for good cause shown as determined by the Medical Staff, have satisfactorily completed the focused professional practice evaluation ; and

(f) Unless otherwise waived by the Governing Board, upon recommendation of the Medical Executive Committee, are certified or are progressing towards certification by boards that are duly organized and recognized by the American Board of Medical Specialties.

5.2-2 Prerogatives

The Prerogatives of an Active Medical Staff Member shall be to:

(a) Admit patients to the Hospital according to member's Privileges;

(b) Exercise such Clinical Privileges as are granted to the Member pursuant to Article VII;

(c) Follow Member's own patients in the Hospital and to provide medical consultation upon request of the attending Member;

(d) Attend Medical Staff meetings and any Staff or Hospital education programs;

(e) Vote on all matters presented at general and special meetings of the Medical Staff and committees on which Member serves; and

(f) Hold office in the Staff organization and committees on which Member serves.

5.2-3 Responsibilities

Each Member of the Active Staff shall:

(a) Meet the basic responsibilities set forth in Section 4.6;

(b) Retain responsibility within Member's area of professional competence for the care and supervision of each patient in the Hospital for whom Member is providing services or arrange a suitable alternate for such care and supervision;

(c) Unless otherwise waived by the Governing Board, upon recommendation of the Medical Executive Committee, **an appointee to the Active Staff must participate in the treatment of a minimum of twelve (12) patients**

within the Hospital during each two-year appointment period. If at the time of reappointment the minimum case criteria are not met then the Medical Staff may provide the Member with an opportunity to request an appointment to the Courtesy Staff or change the Member's status to Courtesy at the time of reappointment.

(d) Actively participate in quality/utilization management activities required of the Staff in supervising appointees of Member's same profession and in discharging such other Staff functions as may from time to time be required;

(e) Accept appointment to and serve on committees to which the Member has been appointed;

(f) Satisfy the requirements set forth in Section 13.7 for attendance at meetings of the Staff and committees on which Member serves; and

(g) Pay dues and assessments as determined by the Medical Staff.

5.3 ACTIVE PROVISIONAL STAFF

5.3-1 Qualifications

The active provisional staff shall consist of Practitioners each of whom are initially appointed to the Medical Staff who are in their Focused Professional Practice Evaluation (FPPE) period.

(a) Meets the basic qualifications set forth in Section 4.2-1;

(b) Have offices or residences, which, in the opinion of the Medical Executive Committee, are located closely enough to the Hospital to provide appropriate continuity of quality care;

(c) Regularly care for patients in this Hospital or are regularly involved in Medical Staff functions, as determined by the MEC.

(d) Active medical staff practitioners are required to complete a minimum of twelve (12) surgical cases within a two-year period;

(e) Except for good cause shown as determined by the Medical Staff, have satisfactorily completed the focused professional practice evaluations; and

(f) Unless otherwise waived by the Governing Board, upon recommendation of the Executive Committee, are certified or are progressing towards certification by boards which are duly organized and recognized by an American Board of Medical Specialties member board.

5.3-2 Prerogatives

The prerogatives of a provisional staff member shall be to:

(a) Admit patients to the Hospital according to Member's Privileges.

(b) Exercise such Clinical Privileges as are granted to Member pursuant to Article VII.

(c) Follow Member's own patients in the Hospital and to provide medical consultation upon request of the attending Member;

(d) Attend Medical Staff meetings and any Staff or Hospital education programs;

(e) Vote on all matters presented at general and special meetings of the Medical Staff, and committees on which Member serves; and

(f) Hold office in the Staff organization and committees on which Member serves.

5.3-3 Responsibilities

Each Member of the Active Provisional category shall:

(a) Meet the basic responsibilities set forth in Section 4.6.

(b) Retain responsibility within Member's area of professional competence for the care and supervision of each patient in the Hospital for whom Member is providing services, or arrange a suitable alternative for such care and supervision.

(c) Unless otherwise waived by the Governing Board, upon recommendation of the Executive Committee, an appointee to the Active Provisional Staff must participate in the treatment of a minimum of twelve (12) patients within the Hospital during each two-year appointment period. If at the time of reappointment the minimum case criteria is not meet then the Medical Staff may provide the Member with an opportunity to request an appointment to the Courtesy Staff or change the members status to Courtesy at the time of reappointment.

(d) Actively participate in quality/utilization management activities required of the Staff in supervising appointees of Member's same profession and in discharging such other Staff functions as may from time to time be required;

(e) Accept appointment to and serve on committees to which the Member has been appointed;

(f) Satisfy the requirements set forth in Section 13.7 for attendance at meetings of the staff and committees on which member serves.

(g) Pay dues and assessments as determined by the Medical Staff.

5.4 COURTESY STAFF

5.4-1 Qualifications

The Courtesy Staff shall consist of Members each of whom:

(a) Meets the basic qualifications set forth in Section 4.2-1;

(b) Do not regularly care for or are not regularly involved in Medical Staff functions as determined by the MEC; and

(c) Courtesy staff practitioners are required to complete a minimum of six (6) surgical cases within a two-year period. If the courtesy practitioner fails to do the required amount of surgical cases, the Medical Staff department may recommend termination of privileges.

(d) Unless otherwise waived by the Governing Board, upon recommendation of the Medical Executive Committee, are certified or are progressing towards certification by boards, which are duly organized and recognized by the American Board of Medical Specialties.

5.4-2 Limitation

Courtesy Staff members who regularly care for or admit patients to the Hospital, as determined by the MEC, shall be obligated to seek appointment to the Active Staff.

5.4-3 Prerogatives

The Prerogatives of a Courtesy Staff Member shall be to:

(a) Admit patients to the Hospital according to member's Privileges;

(b) Exercise such Clinical Privileges as are granted to the Member pursuant to Article VII;

(c) Follow Member's own patients in the Hospital and to provide medical consultation upon request of the attending Member;

(d) Attend Medical Staff meetings and any Staff or Hospital education programs; and

(e) Courtesy Staff Members shall not be eligible to vote, except when serving as a member of a committee, or to hold office in this Medical Staff organization.

5.4-4 Responsibilities

The responsibilities of a Courtesy Staff Member shall be to:

(a) Discharge the basic responsibilities specified in Section 4.6;

(b) Pay dues and assessments as determined by the Medical Staff; and

(c) Provide care to minimum of six (6) patients within the Hospital during each two (2) year appointment period so that the Medical Staff can evaluate clinical competency at the time of reappointment, or provide proof of continued competency at the time of reappointment to the Medical Staff to include

appropriate data associated with the quality of professional practice and/or peer references which validate current competency.

5.5 CONSULTING STAFF

5.5-1 Qualifications

The Consulting Staff shall consist of specialists in various disciplines of care who shall act in an auxiliary capacity to the Active and Courtesy Staff in the management of patients, such as telemedicine, each of whom:

(a) Meets the basic qualifications set forth in Section 4.2-1;

(a) Are Members in good standing of the Medical Staff of another licensed hospital in the State although exceptions to this requirement may be made by the MEC for good cause; and

(b) Unless otherwise waived by the Governing Board, upon recommendation of the Medical Executive Committee, are certified or are progressing towards certification by boards, which are duly organized and recognized by the American Board of Medical Specialties.

5.5-2 Limitation

Consulting Staff Members shall not be eligible to admit patients to the Hospital's inpatient service, but may admit patients to the Hospital's outpatient departments. Members of the Consulting Staff may participate on the Medical Executive Committee and other Medical Staff committees as deemed necessary.

5.5-3 Prerogatives

The Prerogatives of a Consulting Staff Member shall be to:

(a) To provide medical consultation upon request of the attending Member;

(b) Exercise such Clinical Privileges as are granted to the Member pursuant to Article VII;

(c) Attend Medical Staff meetings and any Staff or Hospital education programs; and

(d) Serve as a member of Medical Staff committees.

(e) Consulting Staff Members shall not be eligible to hold office or to vote, except when serving as a member of a committee, or to hold office in this Medical Staff.

5.5-4 Responsibilities

The responsibilities of a Consulting Staff Member shall be to:

(a) Discharge the basic responsibilities specified in Section 4.6 and

(b) Pay dues and assessments as determined by the Medical Staff.

5.6 INITIAL APPOINTMENT

A member who is initially appointed to the Medical Staff is expected to meet the qualifications, prerogatives, obligations, limitations and responsibilities of the category of membership requested.

5.7 LIMITATIONS AND EXCEPTIONS TO STAFF CATEGORY PREROGATIVES

The Prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these Bylaws and by the Medical Staff Rules and Regulations.

5.8 MODIFICATION OF MEMBERSHIP CATEGORY

On its own, upon recommendation of the Performance Improvement Committee, or pursuant to a request by a Member under Section 4.6, the MEC may recommend a change in the Medical Staff category of a Member consistent with the requirements of the Bylaws.

5.9 ADVANCE PRACTICE PROFESSIONALS

The Medical Staff may recommend to the Governing Board the granting of Clinical Privileges to APPs, including, but not limited to physicians' assistants, CRNAs, Chiropractors, and advanced practice nurses, based upon investigation and evaluation of the education, training, experience and demonstrated ability and judgment of individuals requesting Privileges as APPs, according to procedures established in the Bylaws and Rules and Regulations of the Medical Staff. While they are not members of the regular Medical Staff of the Hospital, these Bylaws and the credentialing requirements contained herein will also apply to activities performed by APPs.

5.9-1 Eligible Advance Practice Professionals

Eligibility to provide patient care services in the Hospital will be limited to APPs who are:

(a) Directly employed by the Hospital to provide patient care services;

(b) Employees of any organization under contract with the Hospital;

(c) Employees or contractors of any Physicians Members and who will provide patient care services in the Hospital; or

(d) Professionals who seek Privileges as APPs but do not fall within the above groups.

5.9-2 Qualifications

APPs, who satisfy the eligibility requirements set forth in Section 5.9-1, will each:

(a) Hold a license, certificate or other legal credential as required by State law;

(b) Document their experience, background, education, training, ability, physical health status, and upon request of the credentials committee, mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of competence, quality, and efficiency and that they are qualified to provide a needed service within the Hospital; and

(c) Adhere strictly to the ethics of their respective profession as applicable and work cooperatively with others as determined on the basis of documented references.

Where appropriate, the credentials committee, in consultation with the Chief Executive Officer or designee and the Governing Board, may establish additional qualifications required of members of any particular category of APPs, provided that such qualifications are not founded on an arbitrary or discriminatory basis and are in conformance with applicable law.

5.9-3 Application Procedure

Each person who claims to be eligible as an APP and who makes a written request to apply as an APP at the Hospital, shall be provided with an application form. Any individual who has submitted information consistent with the basic qualifications set forth in Sections 5.9-1 and 5.9-2 shall be eligible for Clinical Privileges as an APP at the Hospital. Each APP's application will be processed and evaluated in accordance with the procedures of Section 6.7 and 6.8 applicable to the Medical Staff, except that applicants shall not be entitled to procedural rights as provided in Article IX unless required by State law.

5.9-4 Specification of Responsibilities

(a) An APP is subject to the same general qualifications, responsibilities and conditions as Members of the Medical Staff, as set forth in Sections 4.2-1, 4.5, 4.6 and 4.7.

(b) The MEC and CEO, with input from the Chief of Staff, shall approve specific written guidelines, or protocols, for the performance of services to be provided by each category of APP. For each category of APP, such guidelines must include, without limitation:

(i) Specification of the classes of patients that may be treated;

(ii) Description of the service to be provided and procedures to be performed; and

(iii) Definition of the degree of assistance that may be provided to a Member on the treating of patients at Hospital and any limitations thereon, including the degrees of Member supervision required for each service.

5.9-5 Prerogatives and Limitations

The Prerogatives and limitations of APPs shall be to:

(a) Provide specified patient care services under the supervision or direction of a Physician Member of the Medical Staff as ordered by the attending physician, or required by state law, except as otherwise expressly provided by the Credentials Committee or the MEC;

(b) Write orders only to the extent established by the Medical Staff but not beyond the scope of the APP's licensure, certificate, or other legal credentials;

(c) Serve on Medical Staff Committees, and other committees as appointed by the Chief of Staff;

(d) Attend Staff, Hospital, and in-service educational programs and clinical meetings related to APP's discipline as required by APP's certification or licensure boards;

(e) Exercise such other Prerogatives as the Credentials Committee or MEC may accord a specific category of APPs, or APPs in general; and

(f) Complete a history and physical examination if granted said Privileges by the MEC and Governing Board and when allowed by State law and demonstrating clinical competency.

A recommendation by or on behalf of the Medical Staff to deny Privileges to an applicant for Privileges as a APP, or to restrict, deny, or to revoke such Privileges, or such a decision by the Governing Board, shall not give rise to any procedural rights set forth in Article IX, unless otherwise specifically provided in the Rules and Regulations of the Medical Staff. APPs shall be given limited procedural rights, including written notice of any final action on the application, and any reason for denial or restriction of the Privileges requested. Additionally, if the Privileges of an APP are modified or revoked, the APP will be provided at a minimum, written reasons for the modification or revocation of Privileges, and a mechanism for appeal to the Governing Board.

5.9-6 Responsibilities

The responsibilities of each APP shall be to:

(a) Meet the responsibilities as set forth in Section 4.6;

(b) Retain appropriate responsibility within APP's area of professional competence for the care and supervision of each patient in the Hospital for whom APP is providing services or alert the attending Physician of the need to arrange a suitable alternative for such care and supervision;

(c) Participate as appropriate in the quality improvement program activities required of the Medical Staff; and

(d) Discharge such other functions as may be required from time to time by the Chief of Staff or MEC.

ARTICLE VI PROCESS FOR APPOINTMENT AND REAPPOINTMENT

6.1 GENERAL PROCEDURE

Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and in the policies adopted by the Hospital. Appointment to the Medical Staff shall confer on the Member only such Clinical Privileges as have been granted in accordance with these Bylaws.

Except as otherwise specified herein, no Practitioner shall exercise Clinical Privileges in the Hospital unless and until he/she:

(a) Applies for and receives appointment to the Medical Staff; or

(b) Is granted temporary Privileges under the conditions as set forth in these Bylaws.

(c) With respect to Advance Practice Professionals, is granted Privileges under applicable Medical Staff Bylaws.

6.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the Clinical Privileges and Staff category or APP designation requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. To the extent consistent with law, this burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the MEC, which may select the examining physician. The applicant may select the examining Physician from an outside panel of three physicians chosen by the Medical Executive Committee.

6.3 COMPLIANCE WITH MEDICAL STAFF RULES

By applying to the Medical Staff for appointment or reappointment, or APP designation the applicant acknowledges responsibility to first review these Bylaws and Medical Staff Rules and Regulations, and policies, and agrees that throughout any period of Medical Staff membership or APP designation that applicant will comply with the responsibilities of Medical Staff membership or APP designation and with the Bylaws, Rules and Regulations and policies of the Medical Staff as they exist and as they may be modified from time to time.

6.4 DURATION OF INITIAL APPOINTMENT

Except as otherwise provided in these Bylaws, initial appointments to the Medical Staff shall be for a period determined by the focused professional practice evaluation. During initial appointment a period of focused professional practice evaluation is implemented and may include, but is not limited to, the following methods of close monitoring related to Privileges granted as deemed appropriate by the MEC: record review, outcomes monitoring, supervision or proctoring as defined in Medical Staff policy.

During the initial appointment period, the Member must demonstrate all of the qualifications, may exercise all of the Prerogatives, must fulfill all of the obligations of his/her Staff category, and must have participated in the treatment of a sufficient number of patients, as required in the Rules and Regulations, so that his/her competence can be evaluated. Upon conclusion of the initial appointment FPPE period, the Credentialing Committee will complete an evaluation of the Member, based on the Member's professional performance, judgment and clinical skills. A summary of the evaluation shall be provided to the MEC to make a recommendation to the Governing Board concerning transfer to Staff category. If at the end of the first year, or sooner if the requisite number of procedures have been completed, additional practical evaluation of a Member's professional conduct is warranted, the MEC may extend the FPPE period.

6.5 APPLICATION FOR INITIAL APPOINTMENT

6.5-1 Application Form

An application form shall be developed by the MEC. The form shall require detailed information which shall include, but not be limited to, information concerning:

(a) The Practitioner's qualifications, including, but not limited to, professional training and education, competence, current licensure, experience, specialty board status, current DEA registration, current state controlled substance registration (if applicable), additional certification and training, and continuing medical education information related to the Clinical Privileges to be exercised by the Practitioner;

(b) Peer references familiar with the Practitioner's current professional competence and ethical character;

(c) Requests for Staff category and Clinical Privileges;

(d) Past or pending professional disciplinary actions or investigations, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of Medical Staff membership, Clinical Privileges or any licensure or registration, and related matters;

(e) Current physical and mental health status statement;

(f) Final judgments or settlements made against the Practitioner in professional liability cases;

(g) Any filed and served claims and cases pending;

(h) Professional liability insurance;

(i) Any pending federal or state investigations; and

(j) A complete list of all hospital Medical Staff memberships held within five (5) years prior to application.

Each application for initial appointment to the Medical Staff shall be in writing, submitted with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the Practitioner.

6.6 EFFECT OF APPLICATION

By applying for appointment to the Medical Staff, the Practitioner:

(a) Pledges to provide for continuous quality care to applicant's patients in the Hospital;

(b) Signifies willingness to appear for interviews in regard to Practitioner's application;

(c) Acknowledges responsibility for timely payment of Medical Staff dues, if a requirement then exists;

(d) Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for the continuous care of the applicant's patients, seeking consultation whenever necessary, and refraining from delegating patient care responsibility to unqualified or inadequately supervised Practitioners, or APPs;

(e) Pledges to be bound by the Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital policies;

(f) Authorizes Hospital Representatives to consult with others who have been associated with Practitioner and/or who may have information bearing on Practitioner's competence and qualifications and to solicit and act upon information, including otherwise privileged or confidential information, provided by third parties bearing on Practitioner's competence and qualifications and agrees that any information so provided shall not be required to be disclosed to applicant if the third party providing such information does so on the condition that it be kept confidential;

(g) Consents to the inspection by Hospital Representatives of all records and documents that may be material to an evaluation of Practitioner's personal and professional qualifications, health status pertinent to performance of professional duties and ability to carry out the Clinical Privileges requested, as well as of Practitioner's professional ethical qualifications for Medical Staff membership;

(h) Authorizes the Hospital to release confidential information, including peer review and/or quality assurance information, obtained from or about the Medical Staff member to other requesting healthcare facilities for the purpose of credentialing activities;

(i) Releases from any liability the Hospital and all Hospital Representatives for their acts performed in good faith and without malice in connection with evaluation of the Practitioner and Practitioner's credentials;

(j) Releases from all liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital Representatives in good faith and without malice concerning the Practitioner's ability, professional ethics,

character, physical and mental health, emotional stability, and other qualifications for Staff appointment and Clinical Privileges;

(k) Agrees that any lawsuit brought by the Practitioner against an individual, or organization providing information to a Hospital Representative, or that any such lawsuit brought against a Hospital Representative, shall be brought in a court, federal or state, in the state in which the defendant resides or is located; and

(l) Agrees to promptly report to the Hospital's Chief Executive Officer or Chief of Staff any new information or changes in the information provided in the application during the time period the application is considered and at any subsequent time if granted membership, any changes in Practitioner's physical or mental health that could impair Practitioner's ability to practice the Privileges granted; any changes in Practitioner's Medical Staff membership or Privileges at any other healthcare facility; any investigation or accusation with regard to Practitioner's state license or controlled substance registration certificate(s); or any adverse changes in Practitioner's professional liability insurance coverage.

6.7 PROCESSING THE APPLICATION

6.7-1 Transmittal for Evaluation

The procedures for transmittal of the application for evaluation shall be as follows:

(a) The Practitioner shall deliver a completely filled-in, signed, and dated application and supporting documents to the CEO or his/her designee and an advance payment of Medical Staff dues or fees, if any is required. The Chief of Staff shall be notified of the application;

(b) The application and all supporting materials then available shall be transmitted to the Medical Staff Coordinator who shall expeditiously seek to collect or verify, the references, licensure status, and other evidence submitted in support of the application. The Hospital's authorized representative shall query the National Practitioner Data Bank regarding the Practitioner and submit any resulting information to the Credentials Committee for inclusion in the Practitioner's credentials file;

(c) The Practitioner shall be notified of any problems in obtaining the information required, and it shall be the Practitioner's obligation to obtain any reasonably requested information; and

(d) When collection and verification of information is accomplished, the application shall be considered complete, and all such information shall be transmitted to the Chief of Staff.

6.7-2 Action by Chief of Staff

After receipt of the application, the Chief of Staff, or his/her designee, shall review the application and supporting documentation, review whether the Privileges requested are within the Hospital's capacity, and may conduct a personal interview with the

Practitioner at his/her discretion. The Chief of Staff, or his/her designee, shall evaluate all matters deemed relevant to a recommendation, including information concerning the Practitioner's provision of services within the scope of Privileges granted, and the Practitioner's participation in relevant continuing education and shall, within thirty (30) days of receipt of the completed application, transmit to the Credentials Committee a written report and recommendation as to appointment and, if appointment is recommended, as to Staff category, Clinical Privileges to be granted, and any special conditions to be attached. The Chief of Staff or his/her designee may also request that the Credentials and/or MEC defer action on the application.

6.7-3 Action by Credentials Committee

The Credentials Committee or committee responsible for credentialing shall review the application, evaluate and verify the supporting documentation, the Chief of Staff's, or his/her designee's, report and recommendations, and other relevant information. The Credentials Committee may elect to interview the applicant and seek additional information. As soon as practicable, the Credentials Committee shall transmit to the MEC a written report and its recommendations as to appointment and, if appointment is recommended, as to membership category, Clinical Privileges to be granted, and any special conditions to be attached to the appointment.

6.7-4 Action by MEC

At its next regular meeting after receipt of the Credentials Committee report and recommendation, the MEC shall examine evidence of the character, professional competence, qualifications, and ethical standing of the Practitioner and shall determine through information provided by the Practitioner's references and from other sources available to the MEC whether the Practitioner meets all of the necessary qualifications for Staff membership and the Clinical Privileges requested. The MEC may request additional information, return the matter to the Credentials Committee for further investigation, and/or elect to interview the Practitioner. The MEC shall forward to the Hospital Chief Executive or Operating Officer, for prompt transmittal to the Governing Board, a written report and recommendation as to Medical Staff appointment and, if appointment is recommended, as to membership category and/or Clinical Privileges to be granted and any special conditions to be attached to the appointment. If the MEC recommendation is adverse to the Practitioner, the reasons for the adverse recommendation will be stated.

If the recommendation of the MEC is favorable to the Practitioner, it shall be promptly forwarded together with supporting documentation to the Governing Board.

If the recommendation of the MEC is adverse to the Practitioner, the Governing Board and the Practitioner shall be promptly informed by written notice of the adverse recommendation and of the Practitioner's right to request a hearing under Article IX.

If procedural rights are waived by the applicant, the recommendations of the Medical Executive Committee shall be forwarded to the Governing Board for final action.

6.7-5 Action by Governing Board

The Governing Board shall consider all recommendations of the MEC. The Governing Board may accept the recommendation of the MEC or may refer the matter back to the MEC for further consideration stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The following procedures shall apply with respect to action on the application:

(a) If the MEC issues a favorable recommendation, the Governing Board shall affirm the recommendation of the MEC if the MEC's decision is supported by substantial evidence;

(b) If the Governing Board concurs in that recommendation, the decision of the Governing Board shall be deemed final action;

(c) If the tentative final action of the Governing Board is unfavorable, the Hospital Chief Executive or Operating Officer shall give the Practitioner written notice of the tentative adverse recommendation and the Practitioner shall be entitled to notice of the procedural rights set forth in Article IX. If the Practitioner waives procedural rights, the decision of the Governing Board shall be deemed final action;

(d) If procedural rights are waived by the Practitioner, the recommendations of the MEC shall be forwarded to the Governing Board for final action, which shall affirm the recommendation of the MEC if the MEC's decision is supported by substantial evidence; and

(e) If the Practitioner requests a hearing following the adverse MEC recommendation pursuant to Section 6.8-4 or an adverse Governing Board action pursuant to 6.8-5(c), the Governing Board shall take final action only after the Practitioner has exhausted all procedural rights as established by Article IX. After exhaustion of the procedures set forth in Article IX, the Governing Board shall make a final decision and shall affirm the decision of the Judicial Review Committee if the Judicial Review Committee's decision is supported by substantial evidence, following a fair procedure. The Governing Board's decision shall be in writing and shall specify the reasons for the action taken. Whichever course of action the Governing Board decides to take under Section 6.8-5, the final responsibility for approval or disapproval of all applications for Staff appointment and Privileges shall rest with the Governing Board.

6.7-6 Notice of Final Decision

Notice of the final decision shall be given in writing to the Chief of Staff, the MEC and the Credentials Committees, the Practitioner, and the CEO.

A decision and notice to appoint or reappoint shall include:

(a) The Staff category to which the Practitioner is appointed;

(b) The Clinical Privileges granted; and

(c) Any special conditions attached to the appointment.

6.7-7 Reapplication after Adverse Appointment Decision

A Practitioner who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of twelve (12) months. Any such reapplication shall be processed as an initial application, and the Practitioner shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

6.7-8 Timeframes for Action on Application

Complete applications are to be acted on within a reasonable period of time. Applications for Staff appointments shall be considered in a timely manner by all persons and committees required by these Bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following maximum time periods provide a guideline for routine processing of applications:

(a) Evaluation, review, and verification of application and all supporting documents by the Medical Staff office: thirty (30) days from receipt of all necessary documentation;

(b) Review and recommendation by Credentials Committee: thirty (30) days after receipt of all necessary documentation;

(c) Review by the MEC: thirty (30) days after review by the Credentials Committee;

(d) Review and recommendation by Governing Board: thirty (30) days after receipt of all necessary documentation from the MEC; and

(e) Final action: one hundred and eighty (180) to after receipt of all necessary documentation by the Medical Staff office or fourteen (14) days after conclusion of hearings.

6.7-9 Expedited Process for Appointment to Medical Staff and Granting Privileges.

An expedited process for appointment to the Medical Staff and granting of Privileges is available when certain criteria have been met. The Governing Board may delegate the authority to render expedited decisions to an Ad Hoc Expediting Committee comprised of at least two (2) voting members of the Governing Board, one of whom will be a Physician. The expedited process may be employed for the initial appointment to Medical Staff membership, reappointment to membership, granting of Privileges, or renewal or modification of Privileges. In order for the Expediting Committee to consider a recommendation, the application must be prepared, submitted, and processed as set forth in Sections 6.8-1 and 6.8-2 addressing applications.

(a) The Practitioner shall be ineligible for the expedited process if:

(i) An incomplete application is submitted; or

(ii) The MEC makes a recommendation that is adverse or has limitations.

(b) The following situations are evaluated on a case-by-case basis and may, at the discretion of the Chief of Staff or CEO/COO, result in ineligibility for the expedited process:

(i) There is a current challenge or a previously successful challenge to the applicant's licensure or registration;

(ii) The Practitioner has received an involuntary termination of Medical Staff membership at any institution;

(iii) The Practitioner has received involuntary limitation, reduction, denial, or loss of Clinical Privileges at any medical institution; or

(iv) The Hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions against the Practitioner.

6.8 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

6.8-1 Application for Reappointment And/or Modifications

At least one hundred and twenty (120) days prior to the expiration date of the current Staff appointment, a reapplication form developed by the MEC shall be mailed or delivered to the Member. If an application for reappointment is not received at least sixty (60) days prior to the expiration date, written notice shall be promptly sent to the Practitioner advising that the application has not been received. At least forty-five (45) days prior to the expiration date, each Medical Staff Member shall submit to the Credentials Committee the completed application form for renewal of appointment to the Staff for the coming year, and for renewal or modification of Clinical Privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the Practitioner including, but not limited to, the matters set forth in Section 6.1, as well as peer review and quality of care indicators. Upon receipt of the application, the information shall be processed as set forth commencing at Section 6.8.

A Medical Staff Member who seeks a change in Medical Staff status or modification of Clinical Privileges may submit such a request, in writing at any time, except that such application may not be filed within 180 days of the time a similar request has been denied.

6.8-2 Effect of Application for Reappointment and/or Modifications

The effect of an application for reappointment or modification of Staff status or Privileges is the same as that set forth in Section 6.7.

6.8-3 Standards and Procedure for Review of Application for Reappointment and/or Modifications

When a Medical Staff Member submits an application for reappointment, and every two (2) years thereafter, or when the Member submits an application for modification of Staff status or Clinical Privileges, the Member shall be subject to an in-depth review generally following the procedures set forth in Sections 6.8-1 through 6.8-8.

6.8-4 Failure to File Reappointment Application

Failure without good cause to timely file a completed application for reappointment pursuant to Section 6.9-1 shall result in the automatic suspension of the Member's admitting Privileges and expiration of other Privileges and Prerogatives at the end of the current Staff appointment. If the Member fails to submit a completed application for reappointment prior to the expiration of Member's Staff appointment, the Member shall be deemed to have resigned membership in the Medical Staff. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article IX shall not apply.

If at the time of reappointment the minimum case criteria is not met then the Medical Executive Committee may provide the Member with an opportunity to request an appointment to the Courtesy Staff or change the members status to Courtesy at the time of reappointment. Such change in Medical Staff category does not constitute a reduction or limitation of privileges or requires the Member to report this category change when making application or reapplication to this or another facility.

6.9 LEAVE OF ABSENCE

6.9-1 Leave of Absence

A Member may request a Medical Staff leave of absence as provided herein. The grant or denial of any such leave has no bearing on the grant or denial of an employment-related leave of absence by a Department. Likewise, the grant or denial of an employment-related leave has no bearing on a request for a Medical Staff leave of absence**.**

(a) A Member may request a Medical Staff leave of absence by submitting a written request to the Chief of Staff with notice to the Chair of the Credentials Committee. The request must state the proposed beginning and ending dates of the leave, which will not exceed one (1) year, along with the reasons for the leave.

(b) The Chief of Staff will determine whether a request for a leave of absence will be granted. The granting of a leave of absence or reinstatement, as appropriate, may be conditioned upon the Member’s completion of all medical records. The granting of a leave of absence shall have no impact on any evaluation, investigation, professional review or corrective actions pending for the Member.

(c) During a leave of absence, the Member will not exercise any clinical privileges. In addition, the Member will be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations).

(d) At least thirty (30) days prior to termination of the leave of absence, the Member may request reinstatement of his/her privileges by submitting a written request to the Chief of Staff that contains a written summary of his/her relevant clinical activities during the leave of absence.

(e) Requests for reinstatement will then be reviewed by the Chief of Staff and the Chair of the Credentials Committee. If the decision for reinstatement is favorable, the Member may immediately resume clinical practice. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee for review and recommendation. However, if a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the Member will be entitled to request a hearing and appeal as provided in Article IX of these bylaws.

(f) Absences of more than six (6) months will result in automatic FPPE. Absences of longer than one year will result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the CEO/COO. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the facility.

(g) If a Member's current appointment period is due to expire during the leave, and the Member does not submit a complete reappointment application in a timely manner, then the Member's appointment and clinical privileges will lapse at the end of the appointment period, and the Member will be required to proceed through the new appointment process. No patient care activities may occur after the expiration date or prior to the Member's new appointment date (if applicable).

(h) Members must report to the Chief of Staff any time they are away from Medical Staff and/or patient care responsibilities for longer than thirty (30) consecutive days and the reason for such absence if related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Failure to comply with this requirement may result in corrective action. In the event of a thirty (30)-day or greater absence, the Chief of Staff may trigger an automatic leave of absence.

(i) Leaves of absence are matters of courtesy, not of right. If it is determined that a Member has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing or appeal.

6.9-2 Medical Leave of Absence

The Chief of Staff and the CEO/COO shall determine the circumstances under which a particular Member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. At the discretion of the Chief of Staff and the CEO/COO, unless accompanied by a reportable restriction of Privileges, the leave shall be deemed a "medical leave" which is not granted for a corrective action. When a medical leave of absence has been granted the Chief of Staff will notify the MEC. The request for reinstatement following a medical leave of absence shall be accompanied by a

report from the Member's treating physician indicating that the Member is physically and mentally capable of returning to a hospital practice and safely exercising the clinical privileges requested.

6.10-3 Military Leave of Absence

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the MEC. Reactivation of membership and Clinical Privileges previously held shall be granted, notwithstanding the provisions of Sections 6.9-5, but may be granted subject to monitoring and/or proctoring as determined by the MEC.

6.10 CURRENT COMPETENCE EVALUATION

6.10-1 General Competencies

For purposes of evaluating current competence, the areas of general competencies include:

(a) Patient care;

(b) Medical/Clinical knowledge;

(c) Practice-based learning and improvement;

(d) Interpersonal and communication skills;

(e) Professionalism; and

(f) Systems-based practice.

6.10-2 Focused Professional Practice Evaluation

Focused professional practice evaluation shall be used to focus evaluation on a specific aspect of a Member's performance and is used in the following two circumstances:

(a) When a Member has the credentials to suggest competence for new clinical privilege(s), but additional information or a period of evaluation is needed to confirm competence in the Hospital; and

(b) If questions arise regarding a Member's professional practice during the course of ongoing professional practice evaluation.

6.10-3 Ongoing Professional Practice Evaluation

Ongoing professional practice evaluation is designed to:

(a) Continuously evaluate a Member's performance;

(b) Evaluate each Member's performance to identify any potential problems with a Member's performance;

(c) Resolve such problems as soon as possible; and

(d) Foster a more efficient, evidence-based Privilege renewal process.

ARTICLE VII DETERMINATION OF CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Every Practitioner or APP providing direct clinical services at the Hospital by virtue of Medical Staff membership or otherwise shall, in connection with such practice, and except as provided in Section 7.4, be entitled to exercise only those Clinical Privileges or provide patient care services as are specifically granted pursuant to the provisions of these Medical Staff Bylaws and the Medical Staff Rules and Regulations.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2-1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the Clinical Privileges desired by the Practitioner or Member. A request by a Member pursuant to Section 6.9 for a modification of Privileges must be supported by documentation of training and/or experience supportive of the request.

7.2-2 Basis for Privileges Determination

The Medical Staff is responsible for developing the Clinical Privileges lists and the criteria for recommending Clinical Privileges to the Governing Board. Requests for Clinical Privileges shall be evaluated on the basis of the Practitioner's education, current licensure and/or certification, training, experience, physical ability to perform the requested privilege, and demonstrated competence and judgment. The basis for PrivilegeS determinations to be made in connection with periodic reappointment or otherwise shall include observed clinical performance, whether the frequency of exercise of Clinical Privileges is sufficient to indicate current proficiency, and the documented results of the quality/utilization management programs, peer review, focused review and other quality maintenance activities required by these Bylaws, accreditation standards and state and federal regulations to be conducted at the Hospital. Privileges determinations may also be based on pertinent information concerning clinical performance obtained from other sources including, but not limited to, other health care facilities where a Practitioner exercises Clinical Privileges. This information shall be added to and maintained in the Medical Staff file established for a Medical Staff member.

Before recommending Privileges, the Medical Staff will evaluate the following:

(a) Challenges to any licensure or registration;

(b) Voluntary or involuntary relinquishment of any license or registration;

(c) Voluntary and involuntary termination of medical staff membership at other health care facilities;

(d) Voluntary or involuntary limitation, reduction or loss of Clinical Privileges at Hospital or other health care facilities;

(e) Any evidence of an unusual pattern or an excessive number of professional liability claims and/or actions resulting in a settlement or final judgment;

(f) Documentation as to health status;

(g) Relevant Practitioner-specific data as compared to aggregate data, when available; and

(h) Morbidity and mortality data, when available.

7.2-3 Procedure

All requests for Clinical Privileges shall be determined by the Governing Board in accordance with the procedures outlined in Article VI.

7.2-4 Clinical Privileges Restricted or Expanded

Periodic re-determination of Clinical Privileges and the expansion or curtailment of Clinical Privileges shall be made at least every two (2) years in conjunction with the application for reappointment. In addition, any Member may request, in writing and on a prescribed form, additional specific Clinical Privileges at any time with information on relevant recent training and/or experience. This application shall be processed in the same manner as an application for initial appointment.

7.2-5 Performance Improvement Program

As a result of performance improvement program findings, the MEC may recommend practice changes, continuing education or proctorship to a Member, and the Member shall be afforded the opportunity to implement those recommendations by written agreement with the MEC. Although the recommendations shall be made in the course of professional review activity, the implementation of the recommendations shall not constitute a complete or final professional review action and shall not entitle the Member to the rights for hearing and appellate review contained in Article IX.

7.2-6 Ongoing Professional Practice Evaluation

Ongoing Professional Practice Evaluation shall be a process for the Medical Staff and Hospital to identify professional practice trends that have an impact on quality of care and patient safety. Such identification may require intervention by the Medical Staff. Relevant information obtained from the Ongoing Professional Practice Evaluation shall be integrated into performance improvement activities. These activities shall adhere to the Medical Staff's and Hospital's policies or procedures intended to preserve any confidentiality or legal privilege of information established by applicable State law.

If there is uncertainty regarding the Member's professional performance, the Medical Staff shall follow the course of action defined in the Bylaws for corrective action.

Ongoing Professional Practice Evaluation information shall be considered in the decision to maintain existing Privilege(s), to revise existing Privilege(s), or to revoke an existing Privilege prior to or at the time of renewal.

The process for the Ongoing Professional Practice Evaluation shall include:

(a) A clearly defined process in place that facilitates the evaluation of each Member's professional practice;

(b) The type of data to be collected shall be determined by the Medical Staff; and

The MEC, pursuant to the Bylaws, evaluates and acts upon reported concerns regarding a Member's clinical practice and/or current competence.

More specific procedural detail is provided in a separate Medical Staff policy titled Professional Practice Evaluation - FPPE / OPPE

7.2-7 Focused Professional Practice Evaluation

All members of the medical Staff shall be subject to Focused Professional Practice Evaluation (FPPE) under certain circumstances.

(a) Initial Appointment

(i) FPPE may be accomplished by multiple methods, but primarily by direct observation, retrospective medical record review, and discussion with others (collectively "proctoring").

(ii) The MEC shall specify the duration of the proctoring period; identify the number of cases to be proctored; explain how cases to be proctored will be selected; specify the method of proctoring; establish standards for when review by an external source will be obtained; and design a monitoring work plan for use by the proctor as outlined in the rules and regulations

(iii) A Practitioner shall remain in proctored status until the Department Chair determines that proctoring requirements have been satisfactorily fulfilled and submits such notification to the ~~Central~~ Peer Review Committee and to the Credentials Committee.

(iv) Hearing and appeal rights shall be deemed waived and not be available to a Practitioner if the decision to deny advancement is based on the Practitioner's failure to meet threshold requirements for the granting of Medical Staff membership and clinical privileges such as board certification or minimum patient encounters.

(v) Hearing and appeal rights shall be available if a Practitioner is denied advancement to full status for reasons related to professional competence or conduct.

(b) Other Applications of FPPE

In addition to evaluating the professional practice of a newly appointed member of the medical Staff, FPPE shall be utilized whenever:

(i) new privileges are awarded, regardless of whether the Practitioner has already achieved full status as a member of the Medical Staff;

(ii) clinical activity is insufficient to evaluate the ongoing clinical performance of a Practitioner; and

(iii) questions about an individual Practitioner's judgment or competence arise.

The procedures for implementing FPPE in such instances shall be the same as in the case of initial appointment.

7.3 TEMPORARY PRIVILEGES

7.3-1 Circumstances

Upon the written concurrence of the Chief of Staff and the CEO or his/her designee, temporary Privileges may be granted for a limited period of time, not to exceed one hundred and twenty (120) days in the following circumstances:

(a) Pendency of Application: After receipt of an application for Medical Staff appointment, including a request for specific temporary Privileges, and in accordance with the conditions specified in Section 7.2-2, an appropriately licensed applicant may be granted temporary Privileges during the pendency of the application. In exercising such Privileges, the Practitioner shall act under the general supervision the Chief of Staff or his designee. Temporary Privileges may be granted upon completion of the following:

(i) verification of current license (verified via the primary source) and required registration or certification;

(ii) verification of relevant training or experience (verified by AMA Profile or another reliable primary source);

(iii) validation of current competency (validated by peer reference or other documentation);

(iv) verification of current professional liability insurance;

(v) validation of ability to perform the Privileges requested (validated by peer references or documentation);

(vi) National Practitioner Data Bank inquiry and evaluation of results;

(vii) receipt of a complete and accurate application;

(viii) verification that Practitioner has no current or previously successful challenge to licensure or registration, has not been subject to involuntary termination of Medical Staff membership at another organization, has not been subject to an involuntary limitation, reduction, denial or loss of Clinical Privileges and has not resigned from a medical staff while under investigation; and

(ix) review and approval of the application by the CEO/COO and Chief of Staff.

(b) Care of Specific Patients: Upon receipt of a written request, an appropriately licensed Practitioner who is not an applicant for Medical Staff membership may be granted Temporary Privileges for the care of one or more specific Hospital patients or under the Emergency Privilege provisions specified in these Bylaws. Primary source verification of licensure and proof of competency must be documented. In addition the Medical Director/Chief of Staff and the CEO/COO must document the granting of Privileges.

(c) Locum Tenens: Upon receipt of a written request, an appropriately licensed Practitioner who is serving as locum tenens for a Member of the Medical Staff may, without applying for membership on the Medical Staff, be granted Temporary Privileges for a period not to exceed one hundred and twenty (120) days. Temporary Privileges may be granted upon completion of the following:

(i) verification of current license (verified via the primary source) and required registration or certification;

(ii) verification of relevant training or experience (verified by AMA Profile or another reliable primary source);

(iii) validation of current competency (validated by peer reference or other documentation);

(iv) validation of ability to perform the Privileges requested (validated by peer references or documentation);

(v) National Practitioner Data Bank inquiry and evaluation of results;

(vi) receipt of a complete and accurate application;

(vii) verification that applicant has no current or previously successful challenge to licensure or registration, has not been subject to involuntary termination of Medical Staff membership at another organization, has not been subject to an involuntary limitation, reduction, denial or loss of Clinical Privileges and has not resigned from a Medical Staff while under investigation; and

(viii) review and approval of the application by the CEO/COO and Chief of Staff.

(ix) Liability insurance

7.3-2 Conditions

Temporary Privileges shall only be granted when there is an important patient care need that mandates an immediate authorization to practice for a limited period of time and while full credentials information is being verified and approved and only when the information available reasonably supports a favorable determination regarding the requesting Practitioner's qualifications, ability and judgment to exercise the Privileges requested, and only after the Practitioner has provided evidence of professional liability insurance in an amount required or from time-to-time may be established. Special requirements of consultation and reporting may be imposed by the Chief of Staff. Before Temporary Privileges are granted, the Practitioner must acknowledge in writing that he has received and read the Medical Staff Bylaws, Rules and Regulations and that he agrees to be bound by the terms thereof in all matters relating to his Temporary Privileges

7.3-3 Termination

On the discovery of any information, or the occurrence of any event, of a professionally questionable nature about a Practitioner's qualifications or ability to exercise any or all of the Temporary Privileges granted, the Chief of Staff may terminate any or all of such Practitioner's Temporary Privileges, provided that where the life or well-being of a patient is determined to be endangered by continued treatment by the Practitioner, the termination may be affected by any person entitled to impose summary suspensions under specified sections of these Bylaws.

In the event of any such termination, the Practitioner's patients then in the Hospital shall be assigned to a Member by the Chief of the Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner. The terminated Practitioner shall confer with the Member to the extent necessary to safeguard the patient.

7.3-4 Rights of the Practitioner

A Practitioner shall not be entitled to the procedural rights afforded by Article IX because of his inability to obtain temporary Privileges or because of any termination, modification or suspension of temporary Privileges.

7.4 EMERGENCY PRIVILEGES

For the purposes 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 the case of an emergency, any Practitioner, to the degree permitted by his or her license, Staff status 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 granted emergency Privileges shall promptly provide to the MEC in writing a statement explaining the circumstances giving rise to the emergency. As soon as practical the Hospital will verify credentials and document the provision of emergency Privileges and specific circumstances associated with the emergency situation.

7.5 DISASTER PRIVILEGES

Disaster Privileges may be granted when the Emergency Management Plan has been activated and the Hospital is unable to handle the immediate patient needs due to the disaster. The CEO/COO or Chief of Staff or their designee(s) has the option to grant Disaster Privileges to volunteer independent licensed Practitioners based on the following requirements:

(a) The Medical Staff authorizes in these Bylaws that the CEO/COO and the Chief of Staff may grant such Privileges for the period limited to the activation of the Emergency Management Plan;

(b) The responsibilities of the person granted Privileges are limited to his/her legal authority to act within their license and specialty to provide care during a disaster period;

(c) A list will be maintained by the Hospital as to the person being granted Disaster Privileges, a copy of their driver's license and a copy of their license to practice issued by a state or federal agency, current picture ID, identification that the individual is a member of a Disaster Medical Assistance Team, or an identification that the individual has been granted authority to render patient care, treatment and services in disaster circumstances by an agency of the federal or state government, may be presented for later verification as soon as the situation is under control. The verification process is identical to that used for new applicants to the Medical Staff;

(d) At least one Member of the Medical Staff must verify the knowledge that the Practitioner being granted Privileges is in fact familiar to them and is eligible to practice in the professional status presented;

(e) Each person granted disaster Privileges will be monitored via direct observation, and clinical record review for appropriate and safe clinical practice: If at any time it is determined that safe practices are not maintained immediate suspension of Disaster Privileges will occur by the Chief Executive Officer;

(f) Primary source verification of licensure will be conducted as soon as practical but not later than seventy-two (72) hours from when the volunteer Practitioner presents to the Hospital; and

(g) The decisions to continue or terminate disaster Privileges will be made by the CEO/COO and Chief of Staff within seventy-two (72) hours of the activation of the Emergency Management Plan.

7.6 SPECIAL CONDITIONS FOR DENTAL PRIVILEGES

Requests for Clinical Privileges by qualified, licensed Dentists shall be processed in the manner specified in Section 7.2. Surgical procedures performed by Dentists shall be under the general supervision of the Chief of Staff and Anesthesia Service area. All dental patients shall receive a prompt medical evaluation by a Practitioner member of the Medical Staff, except that the Medical Executive Committee, based on criteria that include the content of their graduate training programs, may authorize qualified oral and maxillofacial surgeons to perform the physical examinations and secure the histories for their own patients without medical problems. A M.D. or D.O. member of the Medical Staff shall be responsible for the care of any medical

problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

The Dentist is responsible for the dental care of the patient, including the dental history and examination, discharge summary, and all other appropriate elements of the patient's record. Except in the event of an emergency, the responsible Physician Member of the Medical Staff shall be identified prior to admission of the patient for surgery to be performed by a Dentist Member of the Staff.

7.7 SPECIAL CONDITIONS FOR PODIATRIC PRIVILEGES

Requests for Clinical Privileges by qualified, licensed Podiatrists shall be processed in the manner specified in Section 7.2. The delineation of their Clinical Privileges shall be based upon the applicant's training, current experience, judgment and demonstrated competence, consistent with the policy adopted by the Governing Board. The scope and extent of surgical privileges that each Podiatrist may perform must be specifically defined and recommended in the same manner as for all other privileges.

Surgical privileges of Podiatrists shall be limited to the foot and ankle area as specifically outlined by the Medical Executive Committee. Podiatrists with surgical privileges shall be permitted to use the Hospital operating room facilities. Podiatric surgical procedures performed and/or undertaken shall be under the general supervision of the Anesthesia Service area. The nature and degree of supervision shall be a matter of determination in each instance within the Medical Staff policy that governs the usual relationship, and dual responsibility, that should exist between the Medical Staff and the Podiatrist.

It shall be the responsibility of the Podiatrist in each case:

(a) To complete a podiatric history and physical examination and provide for podiatric care;

(b) To arrange for the services of an active or courtesy Medical Staff Member who will be responsible for the medical care of the patient when needed; and

(c) To arrange for the necessary consultations when needed

(d) Each podiatric inpatient shall be admitted under the name of a M.D. or D.O. Member of the Hospital Medical Staff who shall be designated and serve as the attending Practitioner on the case. Except in the event of any emergency admission, the responsible attending Physician Member of the Medical Staff shall be identified prior to the patient's admission for surgery to be performed by a podiatric Member of the Medical Staff.

(e) The attending Physician shall have and assume responsibility for the non-podiatric medical care of the patient including any medical problem that may be present at the time of the admission or that arise during or throughout the hospital stay. The attending Physician shall determine the risk and effect of the proposed podiatric surgical procedure on the total health status of the patient.

(f) It shall be the responsibility of the Podiatrist to complete all medical records of each respective podiatric patient, including the admitting diagnosis, final diagnosis, discharge summary and operative dictation. An admitting progress note shall state a description of the podiatric problem and the reasons in support of any podiatric surgery.

7.8 TELEMEDICINE PRIVILEGES

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

(b) Individuals applying for telemedicine privileges will meet the qualifications for Medical Staff appointment outlined in this Policy, except for those requirements relating to geographic residency, coverage arrangements, and emergency call responsibilities.

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

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

(e) Applications for telemedicine privileges will be processed in accordance with the provisions of these Bylaws in the same manner as for any other applicant, except that the Hospital may utilize the credentialing information provided by the applicant's primary Hospital/group, provided that Hospital/group is accredited by the Joint Commission. There must be a written contract between the primary Hospital/group and the Hospital, the applicant must be privileged at the primary Hospital/group for the privileges being requested, the primary Hospital/group must provide evidence of an internal review of the practitioner’s performance of the privileges, and the primary Hospital/group must provide information about adverse events that resulted from the telemedicine services and any complaints they received about the practitioner.

(f) Telemedicine privileges, if granted, will be for a period of not more than two years.

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

(g) Individuals granted telemedicine privileges will be subject to the Hospital's performance improvement, ongoing and focused professional practice evaluations and peer review activities.

ARTICLE VIII PROCESS FOR CORRECTIVE ACTION

8.1 CORRECTIVE ACTION

8.1-1 Criteria For Initiation

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its Members. The information provided may be processed by the usual Peer Review mechanism and if warranted a recommendation made to the MEC for further action or review. A request for an investigation or action against such Member may be initiated by the Governing Board, Chief of Staff, or the MEC when reliable information indicates a Member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (2) unethical; (3) contrary to the Medical Staff Bylaws and Rules and Regulations or Medical Staff and Hospital policies; or (4) below applicable professional standards.

8.1-2 Initiation

A request for an investigation must be in writing, submitted to the Governing Board or MEC, and supported by reference to specific activities or conduct alleged. If the Governing Board or MEC initiates the request, it shall make an appropriate recording of the reasons and notice provided to the medical staff member under investigation.

8.1-3 Investigation

If the Governing Board or MEC concludes an investigation is warranted, an investigation shall be undertaken by the MEC. The MEC may conduct the investigation itself or assign the task to an appropriate Medical Staff officer or a Standing or Ad Hoc Committee of the Medical Staff. The Governing Board or MEC, in its discretion, may appoint Practitioners who are not members of the Medical Staff as appointed agents of such a committee for the sole purpose of serving on a Standing or Ad Hoc Committee, and not for the purpose of granting these Practitioners temporary Clinical Privileges under Section 7.3, should circumstances warrant. If the investigation is delegated to a Medical Staff officer or committee other than the MEC, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the MEC as soon as practicable. The report may include recommendations for appropriate corrective action. The Member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating officer or committee deems appropriate. The investigating officer or committee may, but is not obligated to, conduct interviews with persons involved. However, such investigation shall not constitute a "hearing" as that term is used in Article IX nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action may be warranted by the

circumstances including summary suspension, termination of the investigative process, or other action.

8.1-4 MEC Action

As soon as practicable after the conclusion of the investigation, the MEC shall take action, which may include, without limitation:

(a) Determining no corrective action be taken. If the MEC determines there was no credible evidence for the complaint in the first instance, it may remove any adverse information from the Member's file;

(b) Deferring action for a reasonable time when circumstances warrant;

(c) Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude the Chief of Staff from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected Member may make a written response, which shall be placed in the Member's file;

(d) Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of Clinical Privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring;

(e) Recommending reduction, modification, suspension or revocation of Clinical Privileges;

(f) Recommending reductions of membership status or limitation of any Prerogatives directly related to the Member's delivery of patient care;

(g) Recommending suspension, revocation or probation of Medical Staff membership; and

(h) Taking other actions deemed appropriate under the circumstances.

8.1-5 Subsequent Action

(a) If corrective action as set forth in Section 9.2(a)-(j) is recommended by the MEC, that recommendation shall be transmitted to the Governing Board.

(b) So long as the recommendation is supported by substantial evidence the recommendation of the MEC shall be adopted by the Governing Board as final action unless the Member requests a hearing, in which case the final decision shall be determined as set forth in Article IX.

8.1-6 Initiation by Governing Board

If the MEC fails to investigate or take disciplinary action contrary to the weight of the evidence, the Governing Board may direct the MEC to initiate investigation or disciplinary action, but only after consultation with the MEC. The Governing Board's

request for Medical Staff action shall be in writing and shall set forth the basis for the request. If the MEC fails to take action in response to that Governing Board's direction, the Governing Board may initiate corrective action after written notice to the MEC, but this corrective action must comply with Articles VIII and IX of these Medical Staff Bylaws.

8.2 SUMMARY RESTRICTION OR SUSPENSION

8.2-1 Criteria For Initiation

Whenever a Medical Staff member's conduct appears to require that immediate action be taken to: 1) protect the life or well-being of patient(s) or 2) reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient, or other person (collectively, "Imminent Danger"), the Chief of Staff, the CEO/COO or the MEC, may summarily restrict or suspend the Clinical Privileges of such Member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the Governing Board, the MEC and the Hospital's CEO/COO In addition, the affected Member shall be provided with a written notice of the action which notice fully complies with the requirements of Section 8.2-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the Member's patients shall be promptly assigned to another Member by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute Member.

8.2-2 Written Notice of Summary Suspension

Within one (1) working day of imposition of a summary suspension, the affected Member shall be provided with written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the summary suspension was reasonably necessary because failure to suspend or restrict the Practitioner's Privileges could reasonably result in an Imminent Danger. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Section 9.3-1 (which applies in all cases where the MEC does not terminate the summary suspension in a timely manner). The notice under Section 9.3-1 may supplement the initial notice provided under this Section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

8.2-3 MEC Action

Within seven (7) business days after such summary restriction or suspension has been imposed, a meeting of the MEC shall be convened to review and consider the action ("Summary Suspension Meeting"). Upon request, the Member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the MEC may impose, although in no event shall any Summary Suspension Meeting of the MEC, with or without the Member, constitute a "hearing" within the meaning of Article IX, nor shall any procedural rules apply. The MEC may modify, continue, or terminate

the summary restriction or suspension, but in any event it shall furnish the Member with notice of its decision within two (2) business days of the Summary Suspension Meeting.

8.2-4 Procedural Rights

Except in the case of a summary suspension of less than fourteen (14) days and unless the MEC promptly terminates the summary restriction or suspension, the Member shall be entitled to the procedural rights afforded by Article IX. In addition, the affected Member shall have the following rights:

(a) Any affected Member shall have the right to challenge imposition of the summary suspension, particularly on the issue of whether or not the facts stated in the notice present a reasonable possibility of Imminent Danger to an individual. Initially, the Member may present this challenge to the MEC at the Summary Suspension Meeting. If the MEC's decision is to continue the summary suspension, then any Member who has properly requested a hearing under the Medical Staff Bylaws may request that the hearing be bifurcated, with the first part of the hearing being devoted exclusively to procedural matters. Along with any other appropriate requests for rulings, the affected Member may request that the hearing officer or hearing panel stay the summary suspension, pending the final outcome of the hearing and any appeal.

(b) At the conclusion of the procedural portion of the hearing, the hearing officer or hearing panel shall issue a written opinion on the issues raised including if a stay has been requested by the affected Member, whether or not the facts stated in the written notice to the affected Member adequately support a determination that failure to summarily restrict or suspend could reasonably result in Imminent Danger. Such written opinion shall be transmitted to both the affected Member and the MEC within one (1) week of the date of the procedural hearing.

(c) If the hearing officer's or hearing panel's determination is that the facts stated in the notice required by Section 8.2-2 do not support a reasonable determination that failure to summarily restrict or suspend the Member's Privileges could result in Imminent Danger, the summary suspension shall be immediately stayed pending the outcome of the hearing and any appeal.

(d) If the hearing officer or hearing panel determines that the facts stated in the notice required by Section 8.2-2 support a reasonable determination that summary suspension was necessary to avoid Imminent Danger, the summary suspension shall remain in effect pending conclusion of the hearing and any appellate review.

8.2-5 Initiation by Governing Board

If the Chief of Staff or members of the MEC are not available to summarily restrict or suspend the Member's Clinical Privileges, the Governing Board, or the CEO/COO as its designee, may immediately suspend a Member's Privileges if a failure to suspend those Privileges is likely to result in an Imminent Danger, provided that the Governing Board or its designee made reasonable attempts to contact the Chief of Staff and Members of the MEC before the summary suspension.

Such a summary suspension is subject to ratification by the MEC. If the MEC does not ratify such a summary suspension within two (2) business days, the summary suspension shall terminate automatically. If the MEC does ratify the summary suspension, all other provisions under Section 8.2 of these Bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the MEC for purposes of compliance with notice and hearing requirements.

8.3 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the Member's Privileges or membership may be suspended or limited as described.

8.3-1 Licensure

(a) Revocation and Suspension: Whenever a Member's license or other legal credential authorizing practice in this State is revoked or suspended, Medical Staff membership and Clinical Privileges shall be automatically revoked as of the date such action becomes effective.

(b) Restriction: Whenever a Member's license or other legal credential authorizing practice in this State is limited or restricted by the applicable licensing or certifying authority, any Clinical Privileges which the Member has been granted at the Hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

(c) Probation: Whenever a Member is placed on probation by the applicable licensing or certifying authority, membership status and Clinical Privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

8.3-2 Controlled Substances

(a) Probation: Whenever a Member's DEA certificate is subject to probation, the Member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

(b) Other Circumstances: Whenever a Member's DEA certificate is revoked, limited, or suspended, the Member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

8.3-3 Medical Records

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the MEC. A limited suspension, in the form of withdrawal of admitting Privileges until medical records are completed, may be imposed

by the Chief of Staff or designee, after notice of delinquency for failure to complete medical records within such period. This limited suspension shall not affect the Member's Privileges for those patients already admitted to the Hospital.

8.3-4 Failure to Pay Dues or Assessments

Failure without good cause as determined by the MEC, to pay dues or assessments, as required under Section 15.2, shall be ground for automatic suspension of a Member's Clinical Privileges, and if within sixty (60) days after written warnings of the delinquency the Member does not pay the required dues or assessments, it shall be considered a voluntary resignation.

8.3-5 Professional Liability Insurance

Failure to maintain professional liability insurance pursuant to coverage limits established by the Governing Board shall be grounds for automatic suspension of a Member's Clinical Privileges and if within thirty (30) days after written warnings of the delinquency the Member does not provide evidence of required professional liability insurance, it shall be considered a voluntary resignation.

8.3-6 Failure to Report Restrictions

Failure to report to the Hospital any restriction or condition imposed on or probation with respect to Member's license or DEA certificate (or state drug registration if applicable) by this State's licensing board upon Member's notice shall be grounds for automatic suspension of a Member's Clinical Privileges.

8.3-7 Failure to Attend Meeting

Failure, without good cause, to appear at a meeting of the Governing Board that has been called in order to discuss proposed corrective action regarding the Member, provided the Member has been given reasonable notice and requested to attend, shall be grounds for automatic suspension of a Member's Clinical Privileges.

8.3-8 Ineligible Person

Whenever a Member shall have his/her name placed on any list of providers excluded from billing Medicare, Medicaid, or any other federal or state healthcare program, Medical Staff membership and Clinical Privileges shall be automatically revoked as of the date such action becomes effective.

8.3-9 MEC Deliberation

As soon as practicable after action is taken or warranted as described in Section 8.3, the MEC shall convene to review and consider the facts, and may recommend any further corrective action as it may deem appropriate in accordance with these Bylaws.

8.3-10 Notification of Suspended Practitioners

The Chief of Staff or designee will send written notice to the automatically suspended practitioner.

ARTICLE IX HEARINGS AND APPELLATE REVIEW

9.1 GENERAL PROVISIONS

9.1-1 Exhaustion of Remedies

If adverse action described in Section 9.2 is taken or recommended, the applicant or Member must exhaust the remedies afforded by these Bylaws before resorting to legal action.

9.1-2 Application of Article

For purposes of this Article, the term "Member" may include "applicant," as it may be applicable under the circumstances, unless otherwise stated.

9.1-3 Timely Completion of Process

The hearing and appeal process shall be completed within a reasonable time.

9.1-4 Final Action

Recommended adverse actions described in Section 9.2 shall become final only after the hearing and appellate rights set forth in these Bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Governing Board.

9.2 GROUNDS FOR HEARING

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing:

(a) Denial of Medical Staff membership;

(b) Denial of requested advancement in Medical Staff membership status;

(c) Denial of Medical Staff reappointment;

(d) Demotion to lower Medical Staff category or membership status;

(e) Summary restriction or suspension of Medical Staff Membership and/or privileges;

(f) Expulsion from Medical Staff Membership;

(g) Denial of requested Clinical Privileges (excluding Emergency Privileges);

(h) Reduction of privileges; and/or

(i) Termination of privileges.

9.3 REQUESTS FOR HEARING

9.3-1 **Right to Request Mediation**

In all cases in which action has been taken or a recommendation made as set forth in Section 9.2, the Member may request the Hospital to participate in mediation regarding the recommendation. The individual must request the mediation in writing to the Chief of Staff within fourteen (14) days of notice of the recommendation. The mediation must be scheduled and completed before a hearing on the recommendation is scheduled. If hearing rights have been waived, the mediation must be scheduled and completed before the recommendation is submitted to the Governing Board for a final decision. The Member shall be required to share the cost of any mediation equally with the Hospital. The mediator shall be qualified as required by state law, and will be selected by the Hospital, with approval by the Member.

9.3-2 Notice of Action or Proposed Action

In all cases in which action has been taken or a recommendation made as set forth in Section 9.2, the Chief of Staff or designee on behalf of the MEC shall give the Member prompt written notice of (1) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the National Practitioner Data Bank if required; (2) the reasons for the recommendation or proposed action including the acts or omissions with which the Member is charged; (3) the right to request a hearing pursuant to Section 9.3-3, and that such hearing must be requested within thirty (30) days; and (4) a summary of the rights granted in the hearing pursuant to the Medical Staff Bylaws. If the recommendation or final proposed action is reportable to the State licensing authority and/or to the National Practitioner Data Bank, the written notice shall state the proposed text of the report(s).

9.3-3 Request for Hearing

The Member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing and addressed to the MEC with a copy to the Governing Board. In the event the Member does not request a hearing within the time and in the manner described, the Member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

9.3-4 Time and Place for Hearing

Upon receipt of a request for hearing, the MEC shall schedule a hearing and give notice to the Member of the time, place and date of the hearing. Unless extended by the Judicial Review Committee, the date of the commencement of the hearing shall be not less than thirty (30) days from the date of notice, nor more than ninety (90) days from the date of receipt of the request by the MEC for a hearing; provided, however, that when the request is received from a Member who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made, so long as the Member has at least thirty (30) days from the date of notice to prepare for the hearing or waives this right.

9.3-5 Notice of Hearing

Together with the notice stating the place, time and date of the hearing, which date shall not be less than thirty (30) days after the date of the notice unless waived by the Member under summary suspension, the Chief of Staff or designee on behalf of the MEC shall provide the reasons for the recommended action, including the acts or omissions with which the Member is charged, a list of the medical records in question, where applicable, and a list of the witnesses, if any, expected to testify at the hearing on behalf of the MEC. The content of this list is subject to update pursuant to Section 9.4-1.

9.3-6 Judicial Review Committee

When a hearing is requested, the MEC shall recommend a Judicial Review Committee to the Governing Board for appointment. The Governing Board shall be deemed to approve the selection unless it provides written notice to the MEC stating the reasons for its objection within five (5) days. The Judicial Review Committee shall be composed of not less than three (3) members of the Medical Staff. The Judicial Review Committee members shall gain no direct financial benefit from the outcome, and shall not have acted as accusers, investigators, fact finders, and initial decision makers or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a Member of the Medical Staff from serving as a member of the Judicial Review Committee. In the event that it is not feasible to appoint a Judicial Review Committee from the Active Staff, the MEC may appoint Members from other Staff categories or Practitioners who are not Members of the Medical Staff. Such appointment shall include designation of the chair. Membership on a Judicial Review Committee shall consist of one Member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the Member. All other Members shall have MD or DO degrees or their equivalent.

9.3-7 Failure to Appear or Proceed

Failure without good cause of the Member to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

9.3-8 Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the hearing officer on a showing of good cause, or upon agreement of the parties.

9.4 HEARING PROCEDURE

9.4-1 Pre-hearing Procedure

(a) If either side to the hearing requests in writing a list of witnesses, within fifteen (15) days of such request, and in no event less than ten (10) days before commencement of the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is reasonably known or

anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing.

(b) Both parties shall have the right to inspect and copy at the party's expense any documents or other evidence relevant to the charges which the other party possesses or controls as soon as practicable after receiving the request.

(c) The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable Members, other than the Member under review.

(d) The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:

(i) Whether the information sought may be introduced to support or defend the charges;

(ii) The exculpatory or inculpatory nature of the information sought, if any;

(iii) The burden imposed on the party in possession of the information sought, if access is granted; and

(iv) Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

(v) The Member shall be entitled to a reasonable opportunity to question and challenge the impartiality of Judicial Review Committee Members and the hearing officer. Challenges to the impartiality of any Judicial Review Committee Member or the hearing officer shall be ruled on by the hearing officer.

(vi) It shall be the duty of the Member and the MEC or its designee to exercise reasonable diligence in notifying the chair of the Judicial Review Committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

9.4-2 Representation

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character.

The Member shall be entitled to representation by legal counsel in any phase of the hearing, if the Member so chooses, and shall receive notice of the right to obtain

representation by an attorney at law. The MEC is entitled to representation by legal counsel in any phase of the hearing, if the Committee so chooses and shall appoint a representative to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions.

9.4-3 The Hearing Officer

The MEC shall recommend a hearing officer to the Governing Board to preside at the hearing. The Governing Board shall be deemed to approve the selection unless it provides written notice to the MEC stating the reasons for its objections within five (5) days. The hearing officer may be an attorney at law qualified to preside over a quasi-judicial hearing but attorneys from a firm regularly utilized by the Hospital, the Medical Staff or the involved Medical Staff Member or applicant for membership for legal advice regarding their affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure, or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as warranted by the circumstances. If requested by the Judicial Review Committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it but the hearing officer shall not be entitled to vote.

9.4-4 Record of the Hearing

A shorthand or court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the reporter shall be borne by the Hospital but the cost of the transcript, if any, shall be borne by the party requesting it. The Judicial Review Committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

9.4-5 Rights of the Parties

Within reasonable limitations as determined by the hearing officer, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The Member may be called by the MEC and examined as if under cross-examination.

9.4-6 Miscellaneous Rules

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing

conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Judicial Review Committee may request or permit both sides to file written arguments. The hearing process shall be completed within a reasonable time after the notice of the action is received; unless the hearing officer issues a written decision that the Member or the MEC failed to provide information in a reasonable time or consented to the delay.

9.4-7 Burdens of Presenting Evidence and Proof

(a) At the hearing the MEC shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The Member shall be obligated to present evidence in response.

(b) An applicant shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and Privileges. An applicant shall not be permitted to introduce information requested by the Medical Staff but not produced during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided in Section 9.4-7(b) for applicants, throughout the hearing, the MEC shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

9.4-8 Adjournments and Conclusion

After consultation with the chair of the Judicial Review Committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the MEC and the Member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

9.4-9 Basis for Decision

The decision of the Judicial Review Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the Judicial Review Committee shall be subject to such rights of appeal as described in these Bylaws, but shall otherwise be affirmed by the Governing Board as the final action if it is supported by substantial evidence, following a fair procedure.

9.4-10 Decision of the Judicial Review Committee

Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee shall render a decision, which shall be accompanied by a report in writing and shall be delivered to the MEC. If the Member is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision also shall be forwarded to the Hospital's Chief Executive or Operating Officer, the Governing Board, and to the Member. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. If the final proposed action adversely affects the Clinical Privileges of a physician for a period longer than thirty (30) days and is based on competence or professional conduct, the decision shall state that the action if adopted will be reported to the National Practitioner Data Bank, and shall state the text of the report as agreed upon by the Committee. The decision shall also state whether the action, if adopted, shall be reported to the State Board of Medicine and shall state the text of the report as agreed by the Committee. Both the Member and the MEC shall be provided a written explanation of the procedure for appealing the decision. The decision of the Judicial Review Committee shall be subject to such rights of appeal or review as described in these Bylaws, but shall otherwise be affirmed by the Governing Board as the final action if it is supported by substantial evidence, following a fair procedure.

9.5 APPEAL

9.5-1 Time for Appeal

Within ten (10) days after receipt of the decision of the Judicial Review Committee, the Member may request an appellate review. A written request for such review shall be delivered to the Chief of Staff and the CEO. If a request for appellate review is not requested within such period, that action or recommendation shall be affirmed by the Governing Board as the final action if it is supported by substantial evidence, following a fair procedure.

9.5-2 Grounds for Appeal

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be:

(a) Substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice;

(b) The decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 9.5-5; and/or

(c) The text of the report(s) to be filed with the State Board of Medicine and the National Practitioner Data Bank is not accurate.

9.5-3 Time, Place and Notice

If an appellate review is to be conducted, the Governing Board shall, within fifteen (15) days after receipt of notice of appeal, schedule a review date and cause the MEC and the Member to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than thirty (30) nor more than sixty (60) days from the date of such notice, provided however, that when a request for appellate review concerns a Member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed fifteen (15) days from the date of the notice. The time for appellate review may be extended by the Governing Board for good cause.

9.5-4 Appeal Board

The Governing Board may sit as the Appeal Board, or it may appoint an Appeal Board that shall be composed of not less than three (3) members of the Governing Board. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney firm selected by the Governing Board shall be neither the attorney firm that represented either party at the hearing before the Judicial Review Committee nor the attorney who assisted the hearing panel or served as hearing officer.

9.5-5 Appeal Procedure

The proceeding by the Appeal Board shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the judicial review hearing, or the Appeal Board may remand the matter to the Judicial Review Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal to present a written statement in support of that party's position on appeal, and to personally appear and make oral argument. The Appeal Board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the Member and MEC and their representatives. The Appeal Board shall present to the Governing Board its written recommendations as to whether the Governing Board should affirm, modify, or reverse the Judicial Review Committee decision consistent with the standard set forth in Section 9.5-6, or remand the matter to the Judicial Review Committee for further review and decision.

9.5-6 Decision

(a) Except as provided in Section 9.5-6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the Governing Board shall render a final decision and shall affirm the decision of the Judicial Review Committee if the Judicial Review Committee's decision is supported by substantial evidence, following a fair procedure.

(b) Should the Governing Board determine that the Judicial Review Committee decision is not supported by substantial evidence, the Governing Board may modify or reverse the decision of the Judicial Review Committee and may instead, or shall, where a fair procedure has not been afforded, remand the matter to the Judicial Review Committee for reconsideration, stating the purpose for the referral. If the matter is remanded to the Judicial Review Committee for further review and recommendation, the Committee shall promptly conduct its review and make its recommendations to the Governing Board. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chair of the Governing Board and the MEC.

(c) The decision shall be in writing, shall specify the reasons for the action taken, shall include the text of the report which shall be made to the National Practitioner Data Bank and the State Board of Medicine, if applicable and shall be forwarded to the Chief of Staff, the Medical Executive and Credential Committees, the subject of the hearing, and the CEO/COO at least ten (10) days prior to submission to the State Board of Medicine.

9.5-9 Right to One Hearing

Except in circumstances where a new hearing is ordered by the Governing Board or a court because of procedural irregularities or otherwise for reasons not the fault of the Member, no Member shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

9.6 EXCEPTIONS TO HEARING RIGHTS

9.6-1 Automatic Suspension or Limitation of Practice Privileges

No hearing is required for automatic suspensions or limitations of Privileges described in Section 8.3-1 and 8.3-2.

9.6-2 Exclusive Contracts

Privileges can be reduced or terminated as a result of a decision by the Governing Board to enter into an exclusive contract for professional services.

9.6-3 Service/Specialty Area Formation or Elimination

All or a separate portion of a new Medical Staff service/specialty area may be formed or eliminated only following a determination by the Governing Board of appropriateness of the service/specialty area elimination or formation.

9.7 EXPUNCTION OF DISCIPLINARY ACTION

Upon petition, the MEC, in its sole discretion, may expunge previous disciplinary action upon a showing of good cause or rehabilitation.

9.8 NATIONAL PRACTITIONER DATA BANK REPORTING

The authorized representative shall report an adverse action to the National Practitioner Data Bank as required by law. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

9.9 DISPUTING REPORT LANGUAGE

If no hearing was requested, a Member who is the subject of a proposed adverse action report to the State Board of Medicine or the National Practitioner Data Bank may request an informal meeting to dispute the text of the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the Member, the Chief of Staff, and the Hospital's authorized representative, or their respective designees. If a hearing was held, the dispute process shall be deemed to have been completed.

ARTICLE X OFFICERS OF THE MEDICAL STAFF

10.1 DESIGNATION

The officers of the Medical Staff shall be:

(a) Chief of Staff

(b) Vice Chief of Staff

(c) Secretary-Treasurer

10.2 QUALIFICATIONS

Officers of the Medical Staff must be current Members of the Active staff in good standing at the time of nomination and election and must remain Members in good standing during their terms of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The officers of the staff must be Members with five (5) years of demonstrated competence in their fields of practice and have demonstrated qualifications on the basis of experience and ability to direct and to lead the Medical Staff in its medical administrative activities.

10.3 NOMINATION OF OFFICERS

(a) If a vacancy exists, a nominating committee shall convene at least thirty (30) days prior to the annual meeting of the Medical Staff, or at least thirty (30) days prior to any special meeting at which an election of Medical Staff officers is to be held. The Nominating Committee shall consist of three (3) members of the MEC. If, for any reason, any of these three individuals is unable to serve, the current presiding officer of the MEC shall appoint another member of the current MEC to serve in his/her place.

(b) The purpose of the Nominating Committee will be to select nominees to fill all existing or anticipated vacancies for the positions of Chief of Staff, Vice Chief of Staff, and Secretary-Treasurer. Such nominations by the Nominating Committee shall be presented in writing to the current Secretary-Treasurer of the Medical Staff at least twenty (20) days prior to the December meeting of the Medical Staff or any special meeting at which an election of Medical Staff officers is to be held. The final slate of nominees shall be chosen upon a two-thirds (2/3) vote of the Committee.

(c) The Secretary-Treasurer shall notify the Members of the active Medical Staff of the nominees in writing no less than fifteen (15) days prior to the date of the election.

(d) Additional nominees may be nominated by the individual Members of the Active Staff. Such nominations must be presented to the Secretary-Treasurer at least twenty (20) days prior to the date upon which the election is to be held.

(e) If, all of the individuals nominated for an office pursuant to Sections 10.1-3(a), 10-3(b) and 10.3-1(d) shall be disqualified from, or otherwise be unable to accept nomination, then the Nominating Committee shall submit one or more substitute nominees at the December meeting, and nominations shall be accepted from the floor.

(f) Except for circumstances delineated in Section 10.1-3(e), nominations from the floor shall not be permitted at any meeting.

10.4 ELECTION OF OFFICERS

Officers shall be elected at the annual meeting of the Medical Staff, or at special meeting at which an election of Medical Staff officers is to be held, or by written ballot in lieu of meeting. In all cases voting shall be by secret written ballot, and voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes.

10.5 TERM OF ELECTED OFFICE

Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff year following election. Each officer shall serve until the end of his/her term and until a successor is elected. Officers may serve unlimited consecutive terms.

10.6 REMOVAL OF OFFICERS

An officer shall be removed from office if a two-thirds (2/3) majority of the Active Staff vote in favor of removal. Grounds for removal shall include, but not be limited to, mental and/or physical impairment and inability or unwillingness to perform the duties and responsibilities of the office. Action directed towards removing an officer from office may be initiated by submission to the MEC of a petition seeking removal of an officer, signed by not less than twenty-five percent (25%) of the Active Staff. Upon receipt of such a petition, a vote on the issue shall be held within thirty (30) days.

10.7 VACANCIES IN MEDICAL STAFF OFFICES

(a) Vacancies in offices, other than that of Chief of Staff, shall be filled by the MEC.

(b) If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall become Chief of Staff and serve out the remaining term.

10.8 DUTIES OF ELECTED OFFICERS

10.8-1 Chief of Staff

The Chief of Staff shall serve as the chief administrative officer and principal elected official of the Staff. As such, the Chief of Staff shall:

(a) Aid in coordinating the activities and concerns of the Hospital administration and of the nursing and other professional staff with those of the Medical Staff;

(b) Be accountable to the MEC and the Governing Board for the quality and efficiency of clinical services and performance within the Hospital and for the effectiveness of the quality/utilization management and other performance improvement functions delegated to the Medical Staff;

(c) Develop and implement methods for credentials review and for delineation of Privileges, continuing education programs, and effective performance improvement programs;

(d) Appoint the Medical Staff representatives to Medical Staff and Hospital committees, unless otherwise expressly provided by these Bylaws or policies and procedures;

(e) Communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the Governing Board, the Chief Executive or Operating Officer of the Hospital, and other officials of the Medical Staff;

(f) Work with the Governing Board and other leaders of the Medical Staff to develop a policy that defines how conflicts of interest that affect or have the potential to affect the safety or quality of care, treatment, or services will be addressed;

(g) Be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Member;

(h) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff; and

(i) Serve as chairman of the MEC and as an ex officio Member without vote of all other Medical Staff committees.

10.8-2 Vice Chief of Staff

The Vice Chief of Staff shall be a member of the MEC. In the temporary absence of the Chief of Staff, he/she shall assume all the duties and have the authority of the Chief of

Staff. He/she shall perform such additional duties as may be assigned to him/her by the Chief of Staff, or the MEC.

10.8-3 Secretary-Treasurer

The Secretary-Treasurer shall be a member of the MEC. Duties of the Secretary-Treasurer shall be to:

(a) Give proper notice of all Staff meetings on order of the appropriate authority;

(b) Supervise the preparation of accurate and complete minutes for all meetings;

(c) Supervise the collection and accounting for any funds that may be collected in the form of Medical Staff dues or assessments, and maintain proper records of such funds;

(d) Render an annual report for presentation at the December meeting of the general Medical Staff each year; and

(e) Perform such other duties as ordinarily pertain to this office.

ARTICLE XI MEDICAL STAFF SERVICE/ SPECIALTY

11.1 ORGANIZATION OF SERVICES

The MEC may recommend the designation of service/specialty subject to Governing Board approval. Clinical Medical Directors may be designated to include, but not limited to: Inpatient Services, Outpatient Services, Physical Therapy, Respiratory Therapy, Emergency Services, Clinical Laboratory and Pathology, and Radiology.

11.2 QUALIFICATIONS, SELECTION, AND TENURE OF SERVICE AREA CHIEFS

11.2-1 Qualifications

In the event that service/specialty are defined each service/specialty chief shall be a Member of the Active Staff and shall be board certified in his/her specialty unless waived.

11.2-2 Selection

Each service/specialty chief shall be recommended by the MEC, subject to approval of the Governing Board.

11.2-3 Tenure

The term of service for each service/specialty chief shall be for 24 months (2 years), commencing on the first day of each Medical Staff year and ending on the last day of each Medical Staff year.

11.2-4 Committee Membership

Service/specialty chiefs shall be members of the MEC

11-2-5 Role in Appointment and Reappointment Process and Delineation of Privileges

If a service/specialty is defined, then the service/specialty chief shall serve as the designee for the Chief of Staff in the appointment and reappointment process as defined in Article VI and Article VII for members of their service/specialty.

11.3 REMOVAL OF SERVICE/SPECIALTY CHIEFS

A service/specialty chief may be removed from office:

(a) Automatically upon summary suspension of Privileges in accordance with the Bylaws;

(b) As effected by a two-thirds (2/3) majority vote of all Active Staff Members of that service, subject to approval by both the MEC and the Governing Board; or

(c) At the discretion of the Chief of Staff.

11.4 FUNCTIONS OF SERVICE/SPECIALTY CHIEFS

Each service/specialty chief is responsible for:

(a) Clinically related activities of the service/specialty;

(b) Administratively related activities of the service/specialty unless otherwise provided for by the Hospital;

(c) The development and implementation of policies and procedures that guide and support the provision of care within the service;

(d) The recommendations for a sufficient number of qualified and competent persons available to provide care and treatment of patients within the service/specialty;

(e) Continuing surveillance of the professional performance of all individuals who have delineated Clinical Privileges in the service area to include those practitioners with clinical privileges assigned to that service/specialty, as well as those assigned to another service/specialty, but awarded certain Privileges in that service/specialty;

(f) Recommendations to the Medical Staff of the criteria for Clinical Privileges in the service/specialty;

(g) Recommendations regarding the award of Clinical Privileges for each Member of the service/specialty and those ~~All~~ practitioners with clinical privileges assigned to another service/specialty, but awarded certain Privileges in that service/specialty;

(h) The assessment and improvement of the quality of care and services/specialties provided;

(i) The maintenance of quality control programs, as appropriate; and

(j) Recommendations for space and other resources needed by the service/specialty.

11.5 FUNCTIONS OF EACH SERVICE/SPECIALTY

11.5-1

Each service/specialty shall establish its own criteria, consistent with the policies of the Medical Staff and of the Governing Board, for the granting of Clinical Privileges in the service/specialty.

11.5-2

Each service/specialty shall conduct a review of committee reports concerning completed records of discharged patients and other pertinent sources of medical information related to patient care. Each service/specialty shall have the responsibility to reach conclusions, make recommendations, and take action on the quality improvement finding of these reviews and to evaluate on-going programs. Such reviews shall include:

(a) Mortality review;

(b) Patients with infections, complications and /or errors in diagnosis and treatment;

(c) Unsolved clinical problems of patients;

(d) Proper utilization of Hospital facilities and services;

(e) Review of surgical matters to include a comprehensive tissue review for justification of all surgery performed; whether or not tissue was removed; acceptability of chosen procedure; and agreement/disagreement between preoperative and pathological diagnoses;

(f) Other significant patient care matters as determined by each service area; and

(g) The service/specialty chiefs, or their designees, shall present periodic reports to the MEC, which will be recorded in the minutes.

11.6 ASSIGNMENTS TO SERVICE/SPECIALTY

11.6-1

The Credentials Committee shall, after consideration of a completed application, recommend initial service/specialty assignments for all Members.

11.6-2

Each Member shall have Clinical Privileges in one or more service/specialty in accordance with their education, training, experience, and demonstrated competence. They shall be subject to all of the rules of such service/specialty and to the jurisdiction of the service/specialty chief involved.

11.6-3

Each Member shall be assigned to one clinical service/specialty for the purpose of participating in the required functions of the Medical Staff, for holding office, and for fulfilling all of the other obligations, which go with Medical Staff appointment.

ARTICLE XII COMMITTEES OF THE MEDICAL STAFF

12.1 GENERAL DESIGNATIONS

Medical Staff committees shall include but not be limited to: (a) The Medical Staff meeting as a Committee of the whole; (b) Meetings of standing committees of the Medical Staff established under this Article; and (c) Meetings of Special or Ad Hoc Committees created by the MEC.

The committees described in this Article shall be the standing committees of the Medical Staff. Special or Ad Hoc Committees may be created by the MEC to perform specified tasks. Unless otherwise specified, the chair and Members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval by the MEC. Medical Staff committees shall be responsible to the MEC. The CEO/COO, in concurrence with the Chief of the Medical Staff, shall appoint Hospital professional personnel to serve on Medical Staff committees as required.

All committees shall maintain a record of attendance at their meetings, maintain a record of their proceedings and submit timely reports of their activities and copies of the minutes of their meetings to the MEC.

12.2 TERMS, VACANCIES AND REMOVAL

12.2-1 Terms of Committee Members

Unless otherwise specified, committee members shall be appointed for a term of twenty-four (24) months. Appointments shall start on the first day of the second month of the Medical Staff year and committee Members shall serve until the last day of the first month of the subsequent Medical Staff year or until the Member's successor is appointed, unless the Member shall sooner resign or be removed from the committee. Committee members may serve consecutive terms.

12.2-2 Removal

If a Member of a committee ceases to be a Member in good standing of the Medical Staff, suffers a loss or significant limitation of Privileges, or if any other good cause exists, that Member may be removed by the MEC.

12.2-3 Vacancies

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided, however, that if an individual who obtains membership by virtue of these Bylaws (e.g., Chief of the Medical Staff) is removed for cause, a successor may be selected by the MEC.

12.3 DESIGNATIONS OF STANDING COMMITTEES OF THE MEDICAL STAFF

There shall be three standing committees of the Medical Staff.

12.3-1 Administrative Committees

The administrative standing committees of the Medical Staff shall be:

(a) MEC; and

(b) Credentials Committee.

12.3-2 Professional Improvement Committees

There shall be a Performance Improvement Committee designated as a standing committee of the Medical Staff.

12.4 MEDICAL EXECUTIVE COMMITTEE

12.4-1 Composition

The MEC shall be a standing committee and shall consist of representatives from each major specialty of the Medical Staff in addition to the Chief of Staff. All Members are eligible for medical staff membership on the MEC but the majority of voting MEC Members must be physicians on the Active Staff. The Chief Executive/Operating Officer and the Chief Nursing Officer will serve as ex-officio Members of the MEC but shall not participate in any proceedings or activities of the MEC when it is acting as a peer review or medical review committee. The MEC has been empowered by the Governing Board for the establishment, maintenance, and improvement of professional and quality care. Therefore, the MEC shall encourage and participate in the ongoing monitoring and review of the factors that relate to quality patient care. The chairperson shall report to the Governing Board. Recommendations and decisions of the MEC will be determined by majority vote of its members.

12.4-2 Duties

The duties of the MEC shall include, but not be limited to:

(a) Representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;

(b) Coordinating and implementing the professional and organizational activities and policies of the Medical Staff;

(c) Receiving and acting upon reports and recommendations from committees, and assigned activity groups;

(d) Recommending actions to the Governing Board on matters of a medical-administrative nature;

(e) Recommending policies regarding the structure of the Medical Staff, the mechanisms to review credentials and delineate individual Clinical Privileges, the granting of individual Medical Staff memberships and recommending Privileges, the organization of quality assessment and improvement activities and mechanisms of the Medical Staff, termination of Medical Staff membership and fair hearing procedures, needed changes to Medical Staff Bylaws, and other matters relevant to the operation of an organized Medical Staff;

(f) Evaluating the medical care rendered to patients in the Hospital and accounting to the Governing Board ;

(g) Participating in the development of all Medical Staff and Hospital policy, practice, and planning with the Hospital administration and the Governing Board;

(h) Reviewing the qualifications, credentials, performance and professional competence, and character of Medical Staff applicants and Members, and making recommendations to the Governing Board at least quarterly regarding Staff appointments and reappointments, Clinical Privileges, and corrective action;

(i) Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all Members including the initiation of and participation in Medical Staff corrective or review measures when warranted;

(j) Taking reasonable steps to develop continuing education activities and programs for the Medical Staff;

(k) Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Chief of Staff;

(l) Reporting to the Medical Staff at each regular staff meeting;

(m) Assisting in the obtaining and maintenance of accreditation;

(n) Developing and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster;

(o) Appointing such Special or Ad Hoc Committees as may seem necessary or appropriate to assist the MEC in carrying out its functions and those of the Medical Staff;

(p) Reviewing the quality and appropriateness of services provided by contract physicians;

(q) Reviewing and approving the designation of the Hospital's authorized representative for National Practitioner Data Bank purposes; and

(r) Establishing a mechanism for dispute resolution between Medical Staff members involving the care of a patient.

12.4-3 Delegation

By these Bylaws, the Medical Staff delegates to the MEC the authority to carry out Medical Staff responsibilities and to act on its behalf between Medical Staff meetings within the scope of its responsibilities as set out above.

Removal of authority that has been delegated to the MEC as set forth above shall require amendment of these Bylaws.

12.4-4 Meetings

The MEC shall meet as often as is necessary but not less than four (4) times a year. The MEC shall maintain a permanent record of its proceedings and actions.

12.5 CREDENTIALS COMMITTEE

12.5-1 Composition

The Credentials Committee shall consist of not less than three (3) members of the Active Staff selected by the Chief of Staff on a basis that will ensure, insofar as feasible, representation of major clinical specialties. The MEC may fulfill the functions of the Credentials Committee.

12.5-2 Duties

The Credentials Committee shall:

(a) Review and evaluate the qualifications of each Practitioner, APP or Member, applying for initial appointment, reappointment, or modification of Clinical Privileges, as applicable;

(b) Submit required reports and information on the qualifications of each Practitioner or APP applying for membership or particular Clinical Privileges including recommendations with respect to appointment, membership category, Clinical Privileges, and special conditions;

(c) Investigate, review and report on matters referred by the Chief of Staff or the MEC regarding the qualifications, conduct, professional character or competence of any applicant, APP, or Medical Staff Member; and

(d) Submit periodic reports to the MEC on its activities and the status of pending applications.

12.5-3 Meetings

The committee shall meet at least quarterly, and more often as necessary to perform its duties, maintain a permanent record of its proceedings and actions and report to the MEC.

12.6 PERFORMANCE IMPROVEMENT COMMITTEE

12.6-1 Composition

The Performance Improvement Committee shall consist of Members of the Active Staff with the minimum number of Members required to be determined by the MEC. The Members shall be selected by the Chief of Staff on a basis that will ensure, insofar as feasible, representation of major clinical specialties. In addition, the Chief Executive or Operating Officer, in concurrence with the Chief of Staff, shall appoint additional Hospital personnel to serve on the Performance Improvement Committee. The Chief of the Staff shall appoint a Member to serve as chair of the Performance Improvement Committee.

12.6-2 Duties

The Performance Improvement Committee shall be responsible for Medical Staff functions relating to quality assessment and improvement, pharmacy and therapeutics, infection control and antibiotic stewardship, tissue review and evaluation, utilization review, quality of medical records, and such other functions as the Governing Board from time to time assigned to this committee. The Performance Improvement Committee will also be responsible for making conclusions and recommendations, taking actions, and evaluating any performance improvement programs functioning within the Hospital.

Specific duties within each functional area for this committee include:

(a) Quality assessment and improvement duties:

(i) Recommend for approval of the Medical Executive Committee systems to identify potential problems in patient care, systems to set priorities for action on problem correction, means to refer priority problems for assessment and corrective action to appropriate committees, methods to monitor the results of quality assessment and improvement activities throughout the Hospital; and techniques to coordinate quality assessment and improvement activities; methods to monitor the results of quality assessment, patient satisfaction and improvement activities throughout the Hospital; and techniques to coordinate quality assessment and improvement activities;

(ii) submitting regular confidential reports to the MEC on the quality of medical care provided and on quality assessment and improvement activities conducted.

(b) Pharmacy and therapeutics duties:

(i) assisting in the formulation of professional practices and policies regarding the continuing evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Hospital, including antibiotic usage;

(ii) advising the Medical Staff and the pharmaceutical service on matters pertaining to the choice of available drugs;

(iii) making recommendations concerning drugs to be stocked in nursing units and in other clinical areas;

(iv) periodically developing and reviewing a formulary or drug list for use in the Hospital;

(v) evaluating clinical data concerning new drugs or preparations requested for use in the Hospital;

(vi) establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;

(vii) maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the MEC concerning those activities;

(viii) developing proposed policies and procedures for, and continuously evaluating the appropriateness of blood and blood products usage, including the screening, distribution, handling and administration, and monitoring of blood and blood components' effects on patients; and

(ix) reviewing untoward drug reactions.

(c) Infection control and antibiotic stewardship duties:

(i) developing and implementing a hospital-wide infection control and antibiotic stewardship program and maintaining surveillance over the program;

(ii) developing and implementing a system for reporting, identifying and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities;

(iii) developing and implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;

(iv) developing written policies defining special indications for isolation requirements;

(v) coordinating action on findings from the Medical Staff's review of the clinical use of antibiotics;

(vi) acting upon recommendations related to infection control and antibiotic stewardship received from the Chief of Staff and the MEC ; and

(vii) reviewing sensitivities of organisms specific to the facility.

(d) Tissue review and evaluation duties:

(i) reviewing of surgical cases in which a specimen (tissue or non-tissue) is removed, as well as from those cases in which no specimen is removed;

(ii) in cases where no specimen is removed, establishing a screening mechanism based upon pre-established criteria, including indications for surgery and all cases in which there is a major discrepancy between the pre-operative and post-operative (including pathologic) diagnosis;

(iii) creating a system whereby tissue review and evaluation functions shall be coordinated with any surgical case reviews.

(e) Utilization review duties:

(i) conducting utilization review studies designed to evaluate the appropriateness of admissions to the Hospital, lengths of stay, discharge practices, use of medical and Hospital services and related factors which may contribute to the effective utilization of services;

(ii) communicating the results of its studies and other pertinent data to the MEC;

(iii) making recommendations for the utilization of resources and facilities commensurate with quality patient care and safety; and

(iv) establishing a utilization review plan which shall be approved by the MEC.

(f) Medical records duties:

(i) assuring that the medical records reflect valid and acceptable documentation of medical events;

(ii) performing periodic review of currently maintained medical records to assure that clinical pertinence and timely completion is maintained; specifically, that each record reflects the diagnosis, results of diagnostic tests, therapy rendered, condition and progress of the patient, and condition of the patient at discharge;

(iii) assuring that the record is sufficiently complete at all times in the event of transfer of physician responsibility for patient care. Recommendations for improvement in documentation, completion or revision or change in

format of the medical record and use of electronic data processing and storage systems for the maintenance of medical records may result; and

(iv) Assuring the patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.

(v) The medical history and physical examination as well as any update examination of the patient, including any changes in the patient's condition, must be completed by a physician or other qualified licensed individual in accordance with state law and Hospital policy. The content of complete and focused history and physical examinations is delineated in the rules and regulations. Only appropriately privileged practitioners may perform and record an H&P.

(g) Invasive procedures review function:

(i) review selection of appropriate invasive procedures

(h) Blood usage review:

(i) evaluate the appropriateness of all transfusions, including the use of whole blood and blood components. All confirmed blood transfusion reactions and policies and procedures relating to the distribution, handling, use and administration of blood and blood components are included; and

(ii) review the adequacy of transfusion services ordering practices for blood and blood products as well as screening mechanisms to identify problems in blood usage;

(i) Morbidity and mortality function:

(i) review of illnesses and deaths including the use of approved criteria for the performance of autopsies. Findings from these reviews are monitored and completed quarterly and used as a source of clinical information in quality assessment and performance improvement activities.

(j) Patient Satisfaction Function

(i) Review the patient satisfaction data seeking opportunities for improvement.

12.6-3 Meetings

The Performance Improvement Committee shall meet at least quarterly, or as often as deemed necessary by the committee chairperson.

ARTICLE XIII MEETINGS

13.1 GENERAL STAFF MEETINGS

13.1-1 Regular Meetings

The Medical Staff shall hold an annual staff meeting each year. The annual meeting is the meeting at which officers of the Medical Staff are elected.

13.1-2 Order of Business and Agenda

The order of business at a regular meeting shall be determined by the Chief of Staff. The agenda shall include at least:

(a) acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting;

(b) administrative reports from the Chief Executive or Operating Officer, Chief of Staff and all standing committees of the Medical Staff;

(c) the election of officers and of representatives to Medical Staff and Hospital committees, when required by these Bylaws;

(d) report by the Chief of Staff on the overall results of quality/utilization management and other performance improvement activities of the Staff, including any recommendations for improving patient care within the Hospital; and

(e) new business.

13.1-3 Special Meetings

Special meetings of the Staff shall be called upon request of the Governing Board, the Chief of Staff, the MEC, or not less than one-third (1/3) of current Members of the active Staff. Special meetings shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.

13.2 COMMITTEE MEETINGS

13.2-1 Regular Meetings

Committees shall, by resolution, provide the time for holding regular meetings, and no notice other than such resolution shall then be required. The frequency of such meetings shall be as required by these Bylaws.

13.2-2 Special Meetings

A special meeting of any committee area shall be called at the request of the chairman of the committee, the Governing Board, the Chief of Staff, or one-third (1/3) of the Committee's current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

13.3 NOTICE OF MEETINGS

Written or printed notice stating the place, day and hour of any regular Staff meeting, of a service meeting, of any special meeting, or of any regular committee meeting not held pursuant to resolution shall be delivered either personally or by mail to each person entitled to be present there at not less than three (3) days nor more than thirty (30) days before the date of such meeting. Notice of committee or service meetings may be given orally. If mailed, the notice of the meeting shall be deemed delivered forty-eight (48) hours after deposited, postage prepaid, in the United States mail, addressed to each person entitled to such notice at his/her address as it appears on the records of the Hospital. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

13.4 QUORUM

13.4-1 General Staff Meetings

The presence of thirty-three percent (33%) or more of the Members of the Active Staff at any regular or special meeting shall constitute a quorum for the purposes of amendment to these Bylaws and the transaction of all other business.

13.4-2 Committee Meetings

Thirty-three percent (33%) of the Active Staff Members of the committee but no fewer than two (2) such Members of a committee shall constitute a quorum at any meeting of such committee.

13.5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the Members present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting by a committee by a writing setting forth the action so taken signed by each Member entitled to vote.

13.6 MINUTES

Minutes of all meetings shall be prepared by the secretary of the meeting and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees, forwarded to the MEC, and made available to the Staff. The secretary-treasurer of the Medical Staff shall maintain a file of the minutes of each meeting.

13.7 ATTENDANCE REQUIREMENTS

13.7-1 Regular Attendance

Each Member of any Medical Staff category that is required to attend meetings shall be required to attend each year:

(a) at least fifty percent (50%) of all Medical Staff meetings duly convened pursuant to these Bylaws; and

(b) at least fifty percent (50%) of all meetings of each committee on which Member serves.

13.7-2 Absence from Meetings

Any Member who is compelled to be absent from any Medical Staff committee meeting shall promptly provide, in writing to the regular presiding officer thereof, the reason for such absence. Unless excused for good cause, failure to meet the attendance requirements of Section 13.7-1 shall be grounds for any of the corrective actions specified in Article VIII, and including, in addition, removal from such committee. Reinstatement of a Member whose membership has been revoked because of absence from meetings shall be made only on application, and any such application shall be processed in the same manner as an application for initial appointment.

13.7-3 Special Appearances

A Member whose patient's clinical course of treatment is scheduled for discussion at a regular committee meeting, may be requested to attend the meeting. If requested, the Member must be given written notice of the matter and of the time and place of the meeting at least five (5) business days prior to the meeting. Whenever possible deviation from standard clinical practice is involved, special notice may be given at least five (5) business days prior to the meeting by the presiding officer or his/her designee and shall include a statement of the issue involved and that the Member's appearance is mandatory. Failure of a Member to appear at any meeting for which Member was given such special notice, shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the Medical Staff Member's Clinical Privileges as the MEC may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the MEC or of the Governing Board or through corrective action, if necessary. If a Member makes a timely request for postponement supported by an adequate showing of good cause the presiding officer may grant postponement of the special appearance.

ARTICLE XIV CONFIDENTIALITY, IMMUNITY AND RELEASES

14.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising Clinical Privileges within this Hospital, an applicant:

(a) Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

(b) Authorizes persons and organizations to provide information concerning such Practitioner to the Medical Staff;

(c) Agrees to be bound by the provisions of this Article XIV and to waive all legal claims against any representative of the Medical Staff or the Hospital who would be immune from liability under Section 14.3 of this Article; and

(d) Acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership or APP designation, the continuation of such membership or designation, and to the exercise of Clinical Privileges at this Hospital.

14.2 CONFIDENTIALITY OF INFORMATION

14.2-1 General

Records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in this Hospital, including, but not limited to, meetings of the Medical Staff meeting as a committee of the whole, meetings of committees, and meetings of Special or Ad Hoc Committees created by the MEC and including information regarding any Member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential.

Access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.

Information which is disclosed to the Governing Board of the Hospital or its appointed representatives in order that the Governing Board may discharge its lawful obligations and responsibilities shall be maintained by that body as confidential.

14.2-2 Breach of Confidentiality

As effective peer review and consideration of the qualifications of Medical Staff Members, APPs, and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff, violates the Medical Staff Bylaws, and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the MEC may undertake such corrective action as it deems appropriate.

14.2-3 Access to Credentials File

A Member shall be granted access to the his/her credentials file, subject to the following provisions:

(a) Notice of such request shall be made by the Member to the Chief of Staff, Chief Executive or Operating Officer or the Chief of Staff's designee;

(b) The Member may review, and receive a copy of, only those documents provided by or addressed personally to the Member. A summary of all other information including peer review committee findings, letters of reference, proctoring reports, or complaints may be provided to the Member, in writing, by the Chief Executive or Operating Officer, within a reasonable period of time, as determined by the Chief Executive or Operating Officer. Such summary may disclose the substance, but not the source, of the information summarized;

(c) The review by the Member shall take place in the Medical Staff office, during normal work hours, with an officer or designee of the Medical Staff present; and

(d) In the event a notice of action or proposed action is filed against a Member, access to that Member's credentials file will be consistent with Section 9.4-1.

14.3 IMMUNITY FROM LIABILITY

14.3-1 For Action Taken

Each representative of the Medical Staff and Hospital shall be immune, to the fullest extent provided by law, from liability to an applicant, Member or APP for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or Hospital.

14.3-2 For Providing Information

Each representative of the Medical Staff and Hospital and all third parties shall be immune, to the fullest extent provided by law, from liability to an applicant, Member or APP for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such person who is, or has been, an applicant to, Member or APP or who did, or does, exercise Clinical Privileges or provide services at this Hospital.

14.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

(a) Application for appointment, reappointment, or Clinical Privileges;

(b) Corrective action;

(c) Hearings and appellate reviews;

(d) Quality improvement or utilization reviews;

(e) Committee or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

(f) Queries and reports concerning the National Practitioner Data Bank, peer review organization, the State Board of Medicine and similar queries and reports.

14.5 RELEASES

Each applicant, Member and APP shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article XIV. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article XIV.

14.6 INDEMNIFICATION

14.6-1 General

The Hospital shall indemnify, defend and hold harmless the Medical Staff and its individual Members from and against losses and expenses (including, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities including, but not limited to, (1) as a member of or witness for a service, committee or hearing panel, (2) as a member of or witness for the Hospital or any Hospital task force, group, or committee, and (3) as a person providing information to any Medical Staff or Hospital group, officer, Governing Board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff Member, APP or applicant. Payment of any losses or expenses by the Medical Staff or Member is not a condition precedent to the Hospital's indemnification obligations hereunder.

14.6-2 Notice Provisions

If any claim relating to the manners to be indemnified pursuant to these Bylaws is asserted, the parties to be indemnified shall give written notice thereof to the Hospital party. Upon receipt of such notice, the Hospital shall have the right to undertake, by counsel or representatives of its choosing, the good faith defense, compromise, or settlement of the claims, such defense, compromise or settlement to be taken on behalf of and for the account and risk for the indemnified party. The indemnified party shall cooperate with the Hospital, in such defense at the Hospital's expense and provide the Hospital with all information and assistance reasonably necessary to permit the Hospital to settle and/or defend any such claim. An indemnified party shall have the right to participate in such defense at its own choice, but such participation shall be at its own expense.

ARTICLE XV RULES, REGULATIONS AND GENERAL PROVISIONS

15.1 RULES AND REGULATIONS OF THE MEDICAL STAFF

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws. Following adoption such Rules and Regulations shall become effective upon approval of the Governing Board, which

approval shall not be withheld unreasonably, or automatically after thirty (30) days if no action is taken by the Governing Board. In the latter event, the Governing Board shall be deemed to have approved the Rules and Regulations adopted by the Medical Staff. Rules and Regulations shall be reviewed at least every three (3) years.

Medical Staff Rules and Regulations shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Medical Staff Member or APP in the Hospital. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting of the Medical Staff or at a regularly scheduled MEC meeting at which a quorum is present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote subject to the approval of the Governing Board.

15.2 DUES OR ASSESSMENTS

The MEC shall have the power to recommend the amount of annual dues or assessments, if any, for each category of Medical Staff membership, subject to the approval of the Medical Staff, and to determine the manner of expenditure of such funds received.

15.3 DIVISION OF FEES

Any division of fees by Members of the Medical Staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

15.4 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service, first-class postage prepaid. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the Medical Staff or officers or committees thereof, shall be addressed as follows:

> Name and proper title of addressee, (if known or applicable) and name of committee, c/o Chief of Staff , address.

Mailed notices to a Member, applicant or other party shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital.

15.5 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices, or to the MEC shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the MEC those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeable result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. A conflict of interest may take many forms, but

arises when a Medical Staff Member in relation to an outside person or organization is in position to influence the Hospital's business or decisions in ways that could led directly or indirectly to financial gain for the Medical Staff Member or Member's family or to give improper advantage to others to the detriment of the Hospital.

15.6 FORMS

Application forms and any other prescribed forms required by these Bylaws for use in connection with Staff appointments, reappointments, delineation of Clinical Privileges, corrective action, notices, recommendations, reports, and other matters shall be adopted by the Governing Board after considering the advice of the MEC.

15.7 TRANSMITTAL OF REPORTS

Reports and other information, which these Bylaws require the Medical Staff to transmit to the Governing Board, shall be deemed so transmitted when delivered, unless otherwise specified, to the Hospital's Chief Executive Officer.

15.8 GOOD STANDING

The Prerogatives and rights provided by these Bylaws to Medical Staff Members to vote at Staff meetings, to be nominated for and to hold Staff office or serve as a Member of the MEC or committee chairman shall be limited to Medical Staff Members in good standing.

15.9 SUBSTANTIAL COMPLIANCE

Minor deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

15.10 PERFORMANCE BY DESIGNEES

Any responsibility assigned, or authority granted, to the Chief Executive or Operating Officer be fulfilled or exercised by another administrative official of the Hospital, designated by the Chief Executive or Operating Officer to perform such function, except as otherwise provided by the Governing Board or in the Hospital Bylaws.

15.11 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

The MEC shall review and make recommendations to the Governing Board regarding quality of care issues related to exclusive arrangements for professional medical services, prior to any decision being made, in the following situations:

(a) The decision to execute an exclusive contract in a previously open portion of a service;

(b) The decision to renew or modify an exclusive contract in a particular portion of a service; and

(c) The decision to terminate an exclusive contract in a particular portion of a service.

15.12 MEDICAL POLICIES AND PROCEDURES

Specific policies and procedures for implementing provisions of the Bylaws and Rules and Regulations may be developed, reviewed and approved by the MEC. Such policies and procedures shall be subject to the approval process in Section 15.1. Agreement by all practitioners with clinical privileges to abide by the Bylaws and Rules and Regulations includes agreement to abide by such policies and procedures. Existing Medical Staff policies and procedures are deemed to continue in effect unless and until amended or replaced by action of the MEC, subject to Governing Board approval.

15.13 JOINT CONFERENCE

Whenever the Governing Board's proposed decision will be contrary to the MEC's recommendation, the Board shall submit the matter to a joint conference of an equal number of Medical Staff and Governing Board members for review and recommendation before making its final decision and giving notice of final decision. Individuals participating in a joint conference will be appointed by the Chief of Staff and Chair of the Board. The MEC or the Board may also request the convening of a joint conference to discuss any matter of controversy or concern that would benefit from enhanced dialogue between Medical Staff and Board leaders.

15.14 CONFLICT MANAGEMENT

The conflict management process shall provide for the joint conference committee to:

(a) Meet as early as possible to identify the conflict,

(b) Include additional parties if essential to resolving the conflict;

(c) Gather information about the conflict;

(d) Work with other representatives of both the Medical Staff and the Governing Board as needed to manage and, when possible, resolve the conflict; and

(e) Protect the safety and quality of care.

The committee may utilize the services of a facilitator or mediator for meetings with the approval of the Chair. The committee shall report to the Medical Executive Committee and Governing Board. If the committee cannot resolve the conflict in a manner agreeable to all parties, the Governing Board shall proceed with a final decision on the issue that gave rise to the conflict.

ARTICLE XVI ADOPTION AND AMENDMENT OF BYLAWS

16.1. GENERAL

Amendment of these Bylaws or repeal and adoption of new bylaws (collectively referred to in this Article as "amendment" or "amendments") may be proposed by: (i) any Medical Staff member, (ii) written petition signed by at least thirty-three percent (33%) of the voting members of the Medical Staff in good standing, (iii) the Medical Executive Committee or any other standing committee of the Medical Staff, (iv) a Joint Hospital Committee, or (v) the Governing Board.

(a) The proposal shall be made in writing to the bylaws committee for consideration, including but not limited to identification of any conflict with these Bylaws or the bylaws of the Governing Board. The bylaws committee shall review the proposal and forward its recommendation, with any recommended revisions to the proposed amendments, to the Medical Executive Committee.

(b) Except as provided under subsection (c) below, the bylaws committee and/or the Medical Executive Committee may modify the proposed amendment (or reject the amendment in which case it is not submitted for vote by the Medical Staff). If recommended by the Medical Executive Committee, the amendment and any recommendations or comments then shall be submitted to the Medical Staff for a vote.

(c) Any amendment proposed as a result of written petition signed by at least thirty three percent (33%) of the voting members of the Medical Staff must be submitted to the Medical Staff for a vote, unless the amendment conflicts with a legal or accreditation requirement.

16.2. NOTICE

Prior to submission for a vote, notice of a proposed amendment must be provided in writing to the voting members of the Medical Staff either by mail, facsimile or by electronic transmission (email) using the contact information currently on file with the Credentials Committee. Amendments may only be considered when the notice specifies that Bylaws amendments shall be on the agenda, and when the recommended changes are sent out as provided above at least twenty (20) days in advance of the meeting.

16.3 APPROVAL OF AMENDMENTS

Amendments to the Bylaws may be considered by the Medical Staff at regular or special meetings called for such purpose following notice under Section (b) above. Absentee voting on amendments is permitted by written ballot submitted in person or by electronic transmission (email), facsimile or by mail to the Credentials Committee and received no later than 5 p.m. on the date of the meeting. Quorum requirements shall be as set forth in Article XIII, except that amendments to the Bylaws shall require approval of thirty-three (33%) of the voting Medical Staff members in good standing present and voting (whether in person or by absentee ballot) at a properly called meeting.

16.4 MODIFICATION

Modifications proposed at any meeting do not require additional notice. Changes shall be effective immediately following and only with the approval by the Governing Board. Medical Staff members shall be notified of approved changes either by mail, facsimile, or electronic transmission (email) using the contact information currently on file with the Credentials Committee, and a copy of the revised Bylaws shall be provided to all Medical Staff members on request.

16.5. PROHIBITION ON UNILATERAL AMENDMENT

Neither the Medical Staff, the Medical Executive Committee, nor the Governing Board may unilaterally adopt or amend the Bylaws.

16.6 EXCLUSIVITY OF MECHANISM

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws. Adoption or amendment of the Medical Staff Bylaws cannot be delegated.

16.7 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. These Bylaws apply with equal force to both genders wherever either term is used.

16.8 ADOPTION OF BYLAWS

These Bylaws together with any appended Rules and Regulations when adopted by the Medical Staff shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Governing Board.

ARTICLE XVII ADOPTION AND AMENDMENT OF MANUALS OR POLICIES

17.1 GENERAL

Adoption and any additions, deletions, or changes (collectively referred to in this Article as "amendment" or "amendments") of a manual or policy governing the Medical Staff may be initiated on the recommendation of the Medical Executive Committee or any other standing committee of the Medical Staff, any Division, any Joint Hospital Committee, Legal Counsel, or the Governing Board, or by the voting members of the Medical Staff as set out below.

17.2 AMENDMENT BY MEDICAL EXECUTIVE COMMITTEE

Any proposal shall be submitted in writing to the Bylaws Committee for review. The Bylaws Committee shall review the proposal and forward its recommendation, with any recommended revisions to the proposed amendments, to the Medical Executive Committee. Amendment of a manual or policy governing the Medical Staff by the Medical Executive Committee requires the approval of two-thirds (2/3rds) of those voting and present at any regular or special meeting of the Medical Executive Committee**.**

(a) At least twenty (20) days prior to submission of an amendment of a manual or policy governing the Medical Staff to the Medical Executive Committee, the Credentials Committee shall notify the Medical Staff of the proposed amendment by mail, facsimile, or electronic transmission (email**)** using the contact information currently on file with the Credentials Committee, and allow the Medical Staff to submit written comments to the Medical Executive Committee within ten (10) days of notice for the Medical Executive Committee's consideration prior to voting on the amendment.

(b) In cases of a documented need for an urgent amendment of a manual or policy governing the Medical Staff necessary to comply with a law or regulation, the Medical Executive Committee may provisionally adopt an amendment and forward it to the Governing Board for approval without prior notification of the Medical Staff as provided above. In such cases, the Credentials Committee shall notify the Medical Staff of the amendment after approval by mail, facsimile, or electronic transmission (email) using the contact information currently on file with the Credentials Committee and provide the Medical Staff with an opportunity to submit written comments to the Medical Executive Committee within ten (10) days of notice. If there is no conflict over the amendment, no further action is required. If there is conflict over the amendment as reflected in written comments submitted by at least twenty percent (20%) of the voting members of the Medical Staff, the conflict resolution process under Section 3.b-c. below shall be implemented by the Medical Executive Committee.

17.3 DISAGREEMENT BETWEEN MEDICAL STAFF AND MEDICAL EXECUTIVE COMMITTEE

In the event of disagreement between the Medical Staff and the Medical Executive Committee on adoption or amendment of a manual or policy governing the Medical Staff, the Medical Executive Committee or the Medical Staff, as set forth below under subsection (a), may request implementation of the following conflict management procedures:

(a) A petition for reconsideration of an issue signed by at least twenty percent (20%) of the voting members of the Medical Staff must be filed with the Credentials Committee within ten (10) days of recommendation or action on the issue by the Medical Executive Committee.

(b) The Medical Executive Committee will call a special meeting of the Medical Staff in accordance with the procedures in these Bylaws to discuss the issue. The Medical Executive Committee may, with the approval of the Hospital CEO/COO, use the services of a facilitator or mediator at that meeting.

(c) Within five (5) days of the meeting, the Medical Executive Committee will reconsider the issue, take a new vote on the issue, and communicate the results of the new vote to the voting members of the Medical Staff by electronic transmission (email), newsletter or other written form.

(d) Amendment by Medical Staff. Subject to the procedures below, by petition signed by at least twenty percent (20%) of the voting members of the Medical Staff, a proposal for amendment of a manual or policy governing the Medical Staff may be presented for vote at a regular or special meeting of the Medical Staff.

(i) At least twenty (20) days prior to presentation at the Medical Staff meeting, the proposed amendment must be submitted to the bylaws committee for review and comment and at least ten (10) days prior to presentation to the Medical Executive Committee for review and comment, with the comments of both the bylaws committee and the Medical Executive Committee presented at the Medical Staff meeting.

(ii) At least one (1) of the members signing the petition must appear at the Medical Staff meeting and present the basis for the amendment. Quorum and voting requirements shall be as set forth in Article XIII, except that approval of the amendment shall affirmative vote of at least two-thirds (2/3rds) of the Medical Staff members present and voting.

17.4 GOVERNING BOARD

Whether the adoption or amendment by the Medical Executive Committee or the Medical Staff, the amendment(s) shall become effective only on approval by the Governing Board. Within ten (10) days of the Governing Board's approval, the Credentials Committee shall send each Medical Staff member written notice of the adopted manual or policy governing the Medical Staff or amendment thereof, either by mail, facsimile, or electronic transmission (email) using the contact information currently on file with the Credentials Committee.

17.5 PROHIBITION ON UNILATERAL AMENDMENT

Neither the Medical Staff, the Medical Executive Committee, nor the Governing Board may unilaterally adopt or amend a Manual or a Policy.

17.6. COMMUNICATION WITH GOVERNING BOARD

Nothing in this Article XVII prevents a Medical Staff member from communicating with the Governing Board on a manual or policy governing the Medical Staff independent of the above process, subject to any procedures established by the Governing Board for such communication.

ARTICLE XVIII EMERGENCY AMENDMENT OR ADOPTION

18.1 EMERGENCY AMENDMENT

In the event there is a documented need for an urgent amendment to the Bylaws, Rules & Regulations, Policy or Manual to comply with any law, regulation or accreditation standard, the MEC may provisionally adopt, and the Governing Board may provisionally approve, such urgent amendment without prior notification to the Medical Staff. In such cases, the Medical Staff will be immediately notified by the MEC and the Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment.

18.2 EMERGENCY ADOPTION

In the event there is a documented need for an urgent adoption of a Policy to comply with any law, regulation or accreditation standard, the MEC may provisionally adopt, and the Governing Board may provisionally approve, such urgent adoption without prior notification to the Medical Staff. In such cases, the Medical Staff will be immediately notified by the MEC and the Medical Staff shall have the opportunity for retrospective review of and comment on the provisional adoption.

18.3 MEDICAL STAFF APPROVAL

All Section 18.1.1 or Section 18.1.2 matters shall be submitted to a vote of the full Medical Staff at the written request of at least twenty-five percent (25%) of the Medical Staff, received within thirty (30) days following approval of such change by the MEC. If the requisite number of requests for a vote is not received, the amendment or adoption will be considered approved by the Medical Staff. To the extent such action is requested in writing by at least twenty-five percent (25%) of the Medical Staff, such matter shall be considered at a regularly schedules or special meeting of the Medical Staff.

ADOPTED by the Medical Staff on

Date: October 20, 2021

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APPROVED by the Medical Executive Committee on

Date: September 13, 2021

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Chief of Staff Signature

APPROVED by the Governing Board on

Date: September 20, 2021

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Governing Board Member Signature

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