MEDICAL STAFF BYLAWS

December 18, 2019

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PREAMBLE

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

DEFINITIONS

1. "Board of Trustees" or "Board" means the Board of Trustees of Clinton Memorial Hospital.

2. "Clinical Privileges" or "Privileges" means the permission granted to a Practitioner by the Board to render specific diagnostic, therapeutic services based upon the individual's professional license, experience, competence, ability and judgment.

3. "Day" means a calendar day unless otherwise specified in a particular context as "working day." A working day does not include weekends or state holidays.

4. "Dentist" means an individual with a D.D.S. degree, or its equivalent, who is fully licensed to practice dentistry and whose practice is in the area of oral and maxillofacial surgery or the area of general dentistry or a specialty thereof.

5. "Ex-officio" means service by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

6. "Hospital" means Clinton Memorial Hospital.

7. "In good standing" means a Practitioner is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operations of the Bylaws, Rules and Regulations, or policy of the Medical Staff.

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

9. "Medical Staff" or "Staff" means those Practitioners who have been duly appointed to the Medical Staff by the Board.

10. "Medical Staff Appointee" or "Appointee" shall mean a Practitioner who is fully qualified for and has been granted appointment to the Medical Staff.

11. "Medical Staff Bylaws" or "Bylaws" mean this governing document, and amendments thereto, of the organized Medical Staff as approved by the Medical Staff and Board.

12. "Medical Staff Policy" or "Policy" means those Medical Staff policies and procedures recommended by the MEC and approved by the Board that supplement the Medical Staff Bylaws and detail Medical Staff processes.

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

14. "Physician" means a graduate of an approved medical or osteopathic school of medicine who is licensed in the State of Ohio or any other state to practice medicine.

15. "Podiatrist" means an individual with a D.P.M. degree who has an unrestricted license to practice podiatry.

16. "Practitioner" means a Physician, Dentist, Podiatrist or Psychologist applying for or currently holding Medical Staff appointment or applying for or currently exercising, Clinical Privileges in the Hospital.

17. "Prerogative" means a participatory right granted, by virtue of Staff category or otherwise, to a Staff Appointee and exercisable subject to the conditions imposed in these Bylaws and in other Hospital and Medical Staff policies.

18. "President & Chief Executive Officer" or "President & CEO" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

19. "Psychologist" means an individual with a doctoral degree in psychology, school psychology, or a doctoral degree deemed equivalent by the Ohio State Board of Psychology who has an unrestricted license to practice psychology.

20. "Rules & Regulations" means the rules and regulations of the Medical Staff that govern the provision of care, treatment, and services to Hospital patients by Practitioners with Privileges at the Hospital

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

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

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

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

OTHER

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

ARTICLE I:

NAME

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

ARTICLE II:

RESPONSIBILITIES

SECTION 2.1. RESPONSIBILITIES

2.1-1 The responsibilities of the Staff are:

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

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

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

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

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

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

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

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

1. education of patients and families;

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

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

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

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

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

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

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

3. regarding the Hospital's annual budget;

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

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

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

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

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

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

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

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

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

practice evaluations (FPPEs) and ongoing professional practice evaluations (OPPEs).

5. implementing a process to identify and manage matters of individual physician health that is separate from the Medical Staff disciplinary function in accordance with the hospital's Impaired Physician Policy & Procedure.

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

1. leadership in activities related to patient safety; and

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

l. To be actively involved in the measurement, assessment and improvement of the following:

1. Use of medications.

2. Use of blood and blood components.

3. Operative and other procedures.

4. Appropriateness of clinical patterns.

5. Significant departures from established patterns of clinical practice.

6. The use of developed criteria for autopsies.

7. Sentinel event data.

8. Patient safety data.

ARTICLE III:

COMPOSITION OF THE MEDICAL STAFF

SECTION 3.1. NATURE OF APPOINTMENT AND PRIVILEGES

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

SECTION 3.2. QUALIFICATIONS

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

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

b. A Practitioner shall not have been terminated from the Medical Staff or received a final adverse initial appointment/Privileges decision from the Clinton Memorial Hospital Board of Trustees within the two (2) years preceding application. This restriction on qualification for application shall not apply to a Practitioner who has been subject to automatic termination of Staff appointment/Privileges pursuant to Section 7.5.

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

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

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

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

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

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

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

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

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

e. Any Practitioner who does not satisfy one (1) or more of the criteria set forth in Section 3.2(d)(1)-(6) above may request that it be waived. The Practitioner requesting the waiver bears the burden of demonstrating that the Practitioner meets the criteria or that other exceptional circumstances exist justifying a waiver. An application that fails to meet eligibility criterion will not be processed until the Board has determined that a waiver should be granted in accordance with this Section.

f. A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the Practitioner in question, input from the relevant Department Chair, and the best interest of the Hospital. The Credentials Committee may also consider the application and additional information that may be provided by the Applicant.

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

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

i. No Practitioner has a right to waiver or to a hearing if the Board denies the requested waiver. Rather the decision to grant a waiver rests solely with the Board. A determination that a Practitioner is not entitled to a waiver is not a denial of privileges or appointment. Instead, the Practitioner is ineligible to request appointment or privileges for failure to meet the baseline qualifications. This ineligibility due to the failure to meet baseline qualification will cause the processing of the Practitioner's application to cease. Not processing the application further due to this ineligibility shall not entitle the applicant to the procedural rights provided in the Fair Hearing Plan.

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

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

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

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

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

SECTION 3.3. OTHER AFFILIATIONS

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

SECTION 3.4. NONDISCRIMINATION

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

SECTION 3.5. PRACTITIONER CONTRACTS

3.5-1 Credentialing Process:

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

3.5-2 Termination of Appointment:

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

SECTION 3.6. INDIVIDUAL RESPONSIBILITIES

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

a. Be reasonably accessible for the performance of professional and Staff duties and obligations at the Hospital. What constitutes "reasonably accessible" will be reviewed yearly or more often by the Credentials Committee in conjunction with the Department involved.

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

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

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

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

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

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

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

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

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

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

6. Adverse status change as a provider in the Medicare or Medicaid programs or of any sanctions or penalties being placed upon him or her by the Centers for Medicare and Medicaid Services (CMS) or any other federal or state

agency as a condition for continued participation in the Medicare Program or adverse finding against the Practitioner by a Medicare Quality Improvement Organization (QIO).

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

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

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

g. Seek consultations whenever required or medically prudent.

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

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

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

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

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

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

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

SECTION 3.7. NATURE AND DURATION OF APPOINTMENTS

3.7-1 Appointment and Reappointment:

a. Appointment

Each appointment to the Medical Staff shall be for a defined period up to a maximum of twenty-four (24) months as granted by the Board or as otherwise provided in the Medical Staff Bylaws or Policies.

b. Reappointment

Reappointment to the Staff shall be for a period of up to twenty-four (24) months.

SECTION 3.8. LEAVE OF ABSENCE

3.8-1 Leave Status:

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

3.8-2 Professional Liability Insurance:

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

3.8-3 Leave Termination:

a. At least forty-five (45) days or at such other time as the Board requires or approves, prior to the termination of the leave of absence, the Appointee must request reinstatement of his appointment, privileges and prerogatives by submitting a written notice to that effect to the Board and the President & CEO. When requested by the Board or President & CEO, the Staff appointee shall submit within ten (10) days of the request a written summary of his relevant activities during the leave of absence.

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

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

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

ARTICLE IV:

CATEGORIES OF THE STAFF

SECTION 4.1. CATEGORIES

The Staff shall be divided as follows: Active, Courtesy, Consulting, Physicians Emeriti, Affiliate, and Telemedicine. The general responsibilities of members of all categories of Staff Appointees are found above in Section 3.6. To the extent the responsibilities of the categories differ, these specific responsibilities are provided below.

SECTION 4.2. ACTIVE STAFF

4.2-1 Qualifications:

The Active Staff shall consist of Practitioners who:

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

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

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

4.2-2 Prerogatives:

An Active Staff Appointee may exercise the following Prerogatives:

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

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

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

4.2-3 Responsibilities:

Each Active Staff Appointee shall:

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

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

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

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

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

SECTION 4.3. CONSULTING STAFF

4.3-1 Qualifications:

The Consulting Staff shall consist of Practitioners who:

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

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

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

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

4.3-2 Prerogatives:

A Consulting Staff Appointee:

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

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

4.3-3 Responsibilities:

A Consulting Appointee shall:

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

SECTION 4.4. COURTESY STAFF

4.4-1 Qualifications:

The Courtesy Staff shall consist of Practitioners who:

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

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

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

4.4-2 Prerogatives:

A Courtesy Appointee may:

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

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

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

4.4-3 Responsibilities:

A Courtesy Appointee shall:

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

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

c. Effective June 1, 2001, provide on call services on a rotating basis to the Emergency Department or other appropriate Hospital area for the evaluation and treatment of patients with potential emergency medical conditions in accordance with the Hospital's Emergency Medical Screening, Treatment, and Transfer Policy and Procedure and Emergency Department Protocols.

d. Effective June 1, 2001, provide inpatient care to patients admitted through the Emergency/Outpatient Services Departments, who have no local attending Practitioner, on a rotating basis per Emergency Department/Outpatient Services Protocols.

e. Effective June 1, 2001, provide follow up care to patients treated and released from the Emergency Department who require such follow up care on an outpatient basis and who have no local attending Physician, on a rotating basis per Hospital Policy and Procedure for Emergency Outpatient Services Referral.

SECTION 4.5. PHYSICIANS EMERITI

4.5-1 Qualifications:

The Physicians Emeriti shall consist of Practitioners who:

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

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

4.5-2 Prerogatives:

Appointees to the Physicians Emeriti Medical Staff category:

a. May attend Staff meetings.

b. May vote at Staff meetings.

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

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

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

f. Shall not be required to pay dues.

g. Shall be required to submit a request to retain Physician Emeriti membership at least every two (2) years; this process shall include a background check.

SECTION 4.6. AFFILIATE STAFF

4.6-1 Qualifications:

The Affiliate Medical Staff shall consist of members who meet the general qualifications set forth in Section 3.2 of these Medical Staff Bylaws and do not provide patient care in this Hospital.

4.6-2 Prerogatives:

Except as otherwise provided, the Affiliate Medical Staff members shall be entitled to:

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

b. Refer patients to Active Staff members or Hospitalists for inpatient treatment. Affiliate Staff may visit their referred patients in the Hospital, review patients'

medical records and receive information concerning patients' medical condition and treatment, but may not participate in any inpatient treatment or make any entries in the medical record;

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

d. Attend continuing medical education programs at the Hospital;

4.6-3 Limitations:

Members of the Affiliate Medical Staff shall not be eligible to:

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

b. Admit and/or treat patients;

c. Order tests on inpatients; or

d. Exercise any clinical privileges.

4.6-4 Appointment and Reappointment Requirements:

At initial appointment and each subsequent reappointment (every two (2) years), information concerning the following shall be collected from the applicant and verified, if applicable:

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

b. Adequate education and training;

c. Appropriate physical and mental health status;

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

e. DEA registration/controlled substance certificate;

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

g. Any allegations of civil or criminal fraud pending against any applicant and any past allegations including their resolution and any investigations by any private,

federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid; and

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

No applicant shall be appointed or reappointed as a member of the Affiliate Staff prior to completion of a query of the National Practitioner Data Bank.

4.6-5 Responsibilities:

Members of the Affiliate Medical Staff will be expected to:

a. Adhere to the ethics of their respective professions;

b. Be able to work cooperatively with others;

c. Complete appointment and reappointment requirements;

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

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

SECTION 4.7. TELEMEDICINE STAFF

4.7-1 Qualifications:

The Telemedicine Staff shall consist of Practitioners who:

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

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

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

4.7-2 Credentialing Requirements

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

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

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

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

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

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

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

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

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

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

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

4.7-3 Prerogatives:

A Telemedicine Staff Member must:

a. treat patients via electronic communication link;

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

c. not admit patients to the Hospital;

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

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

4.7-4 Responsibilities:

Members of the Telemedicine Staff will be expected to:

a. Adhere to the ethics of their respective professions;

b. Be able to work cooperatively with others;

c. Complete appointment and reappointment requirements; and

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

SECTION 4.8. LIMITATION OF PREROGATIVES

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

SECTION 4.9. WAIVER OF QUALIFICATIONS AND PROVISIONS

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

ARTICLE V:

APPOINTMENT, REAPPOINTMENT AND PRIVILEGING

SECTION 5.1. GENERAL PROCEDURE

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

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

SECTION 5.2. INITIAL APPOINTMENT, REAPPOINTMENT, AND PRIVILEGING PROCEDURE

5.2-1 Initial Appointment/Grant of Privileges

a. Application Form

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

b. Content:

i. Information:

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

(1) Provisions necessary to secure the following information to be used in the evaluation of the applicant: evidence the Practitioner requesting Medical Staff appointment

and/or Privileges is the same individual in the credentialing documents; evidence of current licensure; current DEA registration/controlled substance certificate, if applicable; relevant training and/or experience; current competence; adequate professional liability insurance; involvement in any suit against him or her relating to his or her practice and the outcome, whether by settlement, verdict, or otherwise; previously successful or currently pending challenges or limitations to any licensure or registration or the voluntary relinquishment of such licensure or registration; voluntary or involuntary termination or limitation of medical staff membership or temporary or permanent suspension, revocation, reduction, conditioned or limited medical staff appointment or clinical privileges at another hospital or any other health care institution; voluntary or involuntary withdrawal of privileges or limitation or reduction in medical staff status and the reasons for said withdrawal, limitation or reduction, at any other hospital or other health care institution; present and past status as a participant in the Medicare and Medicaid Programs; geographic location of the applicant; and peer recommendations .

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

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

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

ii. Consents

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

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

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

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

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

iii. Confidentiality, Immunity, and Releases from Liability:

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

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

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

iv. Acknowledgments:

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

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

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

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

v. Agreements:

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

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

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

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

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

vi. Falsification of Information or Incomplete Applications:

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

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

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

c. Process

i. Applicant’s Burden:

The applicant shall have the burden of submitting adequate and accurate information for a thorough evaluation of his or her experience, professional ethics, background, training, and demonstrated ability to exercise the Privileges requested with or without a reasonable accommodation; and, further, shall have the burden of resolving any questions about these or any of the qualifications specified in the Bylaws. The applicant shall file the completed application within 90 (ninety) days

after the date the application is made available to him/her. Failure to complete the application within the designated time period will be considered a voluntary withdrawal of the application.

ii. Transmittal and Verification:

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

iii. Credentials Committee Action:

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

considered by the Credentials Committee, all of which shall be transmitted with the recommendation. The Credentials Committee may extend the foregoing sixty (60) day period for the purpose of obtaining additional information for a period not to exceed sixty (60) days, in which case, time for transmission to the Medical Executive Committee of the recommendation shall be increased by the period of extension.

iv. Medical Executive Committee Review

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

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

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

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

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

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

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

v. Board Action

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

a. Defer the application for further consideration. If, as part of its deliberations pursuant to this section, the Board determines that it requires further information, it may defer action and shall notify the applicant and the Chief of Staff in writing of the deferral and the grounds therefore. If the applicant is to provide the additional information, the Board chair shall advise the applicant, by Special Notice, including a request for the specific data/explanation or release/authorization, if any, required from the applicant and the time frame for response. Failure by the applicant, without good cause, to respond with the requested information within the time frame specified shall be deemed a voluntary withdrawal of the application without right to the procedural rights set forth in the Medical Staff Bylaws.

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

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

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

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

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

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

(4) If the Board is to receive an adverse MEC recommendation, the Chief of Staff shall withhold the recommendation and not forward it to the Board until after the Chief of

Staff notifies the applicant by Special Notice of the recommendation, and the applicant's right to the procedural rights provided for in the Bylaws, and the applicant either exercises or waives such rights.

(5) In the event that an applicant withdraws his/her initial application prior to commencement of a hearing, the withdrawal shall be deemed to be a voluntary withdrawal of the application, and the applicant's file shall be closed. Upon the commencement of a hearing on an initial application, the application may no longer be voluntarily withdrawn; rather the process shall be completed and a final decision rendered by the Board.

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

vi. Conflict Resolution

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

vii. Reapplication

Any applicant who has received a final adverse decision regarding Medical Staff appointment and/or Privileges shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of two (2) years. Any such reapplication shall be processed as an initial application. The applicant shall submit information and bear the burden of demonstrating that the basis for the earlier adverse action no longer exists.

SECTION 5.3. REAPPOINTMENT

5.3-1 Form:

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

5.3-2 Content:

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

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

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

5.3-3 Professional Practice Evaluation Data

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

5.3-4 Processing

a. Transmittal and Verification

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

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

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

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

b. Process

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

c. Basis of Recommendation

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

SECTION 5.4. VOLUNTARY RESIGNATION

Any Practitioner submitting a voluntary resignation must submit the request to the Performance Improvement Department in writing at least thirty (30) days prior to the

effective date of the voluntary resignation. The request is then submitted to the Credentials Committee, MEC and the Board for their information.

SECTION 5.5. ADDITIONAL CLINICAL PRIVILEGES

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

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

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

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

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

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

    (b) If the Board determines not to approve the criterion for the new Clinical Privileges, the requesting Practitioner shall be notified by the appropriate party that the Clinical Privileges will not be

provided in the Hospital and the Practitioner 's request for such Privileges will be considered automatically and voluntarily withdrawn without right to hearing or appellate review

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

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

SECTION 5.6. AMENDMENT OF CURRENT PRIVILEGE SET

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

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

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

SECTION 5.7. APPOINTMENT WITHOUT PRIVILEGES

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

5.7-2 If time constraints so require, an application for Affiliate appointment may be acted upon by the Hospital President & CEO upon recommendation of the Chief of Staff.

5.7-3 Denial of an application for Affiliate appointment shall not trigger procedural due process rights nor shall it create a reportable event for purposes of federal or state law.

SECTION 5.8. FAILURE TO PRACTICE ACTIVELY

5.8-1 Active Staff:

a. An Active Staff Appointee must admit, attend, consult or render professional services on the Hospital premises as documented in the medical record in the care of at least 12 patients each calendar year of appointment and must fulfill the responsibilities of Active Staff. If these conditions are not met, his or her Staff appointment will be automatically reduced to Courtesy Staff provided that the

Practitioner otherwise satisfies the requirements for Courtesy Staff appointment. Reduction in staff category shall be final 30 days after notice to the Appointee. During those 30 days, the Appointee may submit documentation that the requirements for Active Staff have been met. Upon the expiration of the 30 day period, Hospital Administration shall confirm or reject the automatic reduction, taking into account any documents submitted by the affected appointee.

b. Automatic reduction of Staff category as described in this Section 5.3-1 is not adverse to the Practitioner and shall not give rise to the hearing rights set forth in Article VIII.

5.8-2 Courtesy Staff:

a. A Courtesy Staff Appointee must admit, attend, consult or render professional services on the Hospital premises as documented in the medical record in the care of at least one (1) patient for each calendar year of appointment and must fulfill the responsibilities of Courtesy Staff. If these conditions are not met, the Appointee's Medical Staff appointment/Privileges will be automatically terminated or the appointment will be automatically reduced to Affiliate Staff status if the Practitioner otherwise meets the qualifications for Affiliate Staff. Termination/reduction of Staff category shall be final 30 days after notice to the Appointee. During those 30 days, the Appointee may submit documentation that the requirements for Courtesy Staff have been met. Upon the expiration of the 30 day period, Hospital Administration shall confirm or reject the automatic termination/reduction, taking into account any documents submitted by the affected Appointee.

b. Automatic termination of Staff appointment/Privileges or reduction of Medical Staff category as described in this Section 5.3-2 is not adverse to the Practitioner and shall not give rise to the hearing rights set forth in Article VIII. Reinstatement to Courtesy Staff for an Appointee whose appointment/Privileges have been revoked because of failure to practice actively shall be made only upon application and any such application shall be processed in the same manner as an application for initial appointment/Privileges.

SECTION 5.9. MODIFICATION OF APPOINTMENT/PRIVILEGES

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

SECTION 5.10. REPORTING OF INFORMATION

5.10-1 Reporting:

The Chief of Staff and Director of Credentialing shall review information to be reported to governmental authorities for accuracy only. Copies of information to be reported shall be delivered to the affected Practitioner after the foregoing review, but before transmission to governmental authority.

5.10-2 Adverse Actions:

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

SECTION 5.11 WITHHOLDING FOR HOSPITAL'S INABILITY TO ACCOMMODATE APPLICANT

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

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

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

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

However, upon written request of the applicant, the application shall be kept in a pending status for the next succeeding two (2) years. If during this period, the Hospital finds it possible to accept applications for staff positions for which the applicant is eligible, and the Hospital has no obligation to applicants with prior pending status, the CEO or his/her designee shall promptly so inform the applicant of the opportunity by special notice.
Within thirty (30) days of receipt of such notice, the applicant shall provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his/her original application. Thereafter, the procedure provided for initial appointment shall apply.

ARTICLE VI:

CLINICAL PRIVILEGES

SECTION 6.1. EXERCISE OF PRIVILEGES

6.1-1 General:

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

SECTION 6.2. DELINEATION

6.2-1 Requests:

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

6.2-2 Procedure:

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

6.2-3 Basis:

Requests for Clinical Privileges shall be evaluated and justified on the basis of information compiled pursuant to applications for appointment and reappointment, as

well as on community and hospital need, available facilities, equipment and number of qualified support personnel and resources and as determined by the Medical Staff Development Committee.

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

6.2-4 Duration:

Clinical Privileges are granted for a period commensurate with the duration of appointment or reappointment, as applicable, but in no event shall any grant of Clinical Privileges exceed two (2) years.

SECTION 6.3. ADMITTING PRIVILEGES; HISTORY AND PHYSICAL

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

6.3-1 Dentist:

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

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

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

6.3-2 Podiatrists:

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

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

6.3-3 Psychologists:

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

6.3-4 Medical History and Physical Examination Requirements:

a. Each qualified physician (or other licensed independent practitioner who has been credentialed and granted privileges to perform a history and physical examinations) shall complete an admission history and physical examination for every patient admitted for inpatient care within twenty-four (24) hours of admission, and immediately prior to any procedure(s) requiring anesthesia or sedation. A written admission note shall be entered at the time of admission, documenting the diagnosis and reason for admission. Oral/maxillofacial surgeons may be granted privileges to perform part or all of the history and physical examination, including assessment of the medical, surgical and

anesthetic risks of the proposed operation or other procedure. This report shall include an age-specific assessment of the patient and shall include all pertinent findings documenting the need for the admission. In the case of infants, children or adolescents, the report shall include immunization status and other pertinent age-specific information. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the history and physical shall specifically document the circumstances surrounding the need for additional acute care. Should the physician fail to ensure that the patient's history and physical is dictated in time to be transcribed and on the chart within twenty-four (24) hours after admission, the record shall be considered incomplete and the Chief of Staff or his/her designee or the CEO or his designee may take appropriate steps to enforce compliance, including but not limited to immediate suspension from scheduling and/or performing non-emergent elective procedures within the Hospital until completed. If the history and physical is completed by a licensed independent practitioner who is not a physician or oral and maxillofacial surgeon, the findings, conclusions and assessment of risk must be endorsed by a qualified physician prior to surgery, invasive diagnostic or therapeutic interventions, induction of anesthesia/sedation, or other major high risk procedures.

b. A history and physical performed within thirty (30) days prior to hospital admission may be used, as long as the medical record contains durable, legible practitioner documentation indicating the H&P was reviewed, and noting that “no change” has occurred or noting any changes in the patient’s condition not consistent or otherwise reflected in the H&P. If there have been any changes in the patient’s condition that are not consistent with or noted in the history and physical, those must be documented within twenty-four (24) hours of admission, and immediately prior to any procedure(s) requiring anesthesia or sedation.

SECTION 6.4. LOCUM TENENS

Practitioners seeking locum tenens Privileges shall submit an application for such Privileges and shall have such application processed in accordance with Section 5.2-1. An approved application for Privileges as a locum tenens shall be valid for a period of two (2) years. [Privileges shall be granted for a period not to exceed sixty (60) days as recommended by the MEC and approved by the Board.] In exceptional circumstances a locum tenens may initially qualify for temporary Privileges. If privileges renewed after 60 days, certain components may need to be updated. For purposes of this Section, the term "locum tenens" shall include Practitioners providing temporary coverage during another Practitioner's absence (e.g. due to illness, vacation etc.) and those Practitioners who provide additional temporary staffing at the Hospital as needed from time to time at the request of the Hospital.

SECTION 6.5. TEMPORARY PRIVILEGES

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

Upon recommendation of the Chief of Staff, the President & CEO may grant temporary Privileges on a case-by-case basis in the following circumstances:

a) Pendency of a Completed Application. To an applicant for new Privileges but only after: receipt of a completed application; consultation with the Director of the applicable Department ; verification of the qualifications required by the Bylaws relating to current licensure, competency and relevant professional education, training and experience; DEA controlled substances registration; adequate professional liability insurance; completion of National Practitioner Data Bank queries; a fully positive written reference specific to the Practitioner's current competence for the Privileges being requested from a responsible medical staff authority at the Practitioner's current hospital affiliation; ability to perform the Clinical Privileges requested; results of a criminal background check; and a positive recommendation by the Credentials Committee; or, if so authorized by the Credentials Committee, the Director of Credentialing (as the Credentials Committee chair). Along with the completed application, the record must establish that the applicant has no current or previously successful challenges to his/her licensure; has not been subject to the involuntary termination of his/her medical staff appointment at another organization; has not been subject to any involuntary limitation, reduction, denial or loss of privileges; and, has not been suspended or terminated from any Federal Healthcare Program.

Temporary Privileges may be granted in this circumstance for a period not to exceed the pendency of the application or one hundred twenty (120) days, whichever is less. Under no circumstances may temporary Privileges be initially granted or renewed if the application is still pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information .

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

Practitioner's current hospital affiliation; results of a National Practitioner Data Bank query; and results of a criminal background check.

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

SECTION 6.6. EMERGENCY PRIVILEGES

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

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

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

SECTION 6.7. DISASTER PRIVILEGES

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

The President & Chief Executive Officer or Chief of Staff may grant such disaster Privileges on a case-by-case basis after verification of a valid government-issued picture identification in addition to at least one of the following: (i) primary source verification of licensure; (ii) a current license to practice; (iii) a current picture identification card from a health care organization that identifies professional designation; (iv) identification indicating the individual is a member of a Disaster Medical Assistance Team ("DMAT"), The Medical Reserve Corps. ("MRC"), the Emergency System for Advance Registration of Volunteer Health Professionals ("ESAR-VHP") or other recognized state or federal response organization or group; (v) identification indicating the individual has been granted authority to render patient care, treatment or services in disaster circumstances by a

government entity; or, (vi) confirmation of the identity of the volunteer Practitioner and his/her qualifications by a Hospital employee or Practitioner with Hospital Privileges.

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

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

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

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

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

SECTION 6.8. TERMINATION

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

A Practitioner who has been granted temporary, locum tenens, disaster, or telemedicine Privileges is not entitled to the procedural rights provided in the Medical Staff Bylaws. A Practitioner shall not be entitled to the procedural due process rights set forth in the Medical Staff Bylaws because a request for temporary, locum tenens, disaster, or telemedicine Privileges is denied, in whole or in part, or because all or any portion of such Privileges are terminated, not renewed, restricted, suspended or otherwise limited, modified or monitored in any way.

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

SECTION 6.9 PROFESSIONAL PRACTICE EVALUATION

6.9-1 Focused Professional Practice Evaluation. The Hospital's focused professional practice evaluation (FPPE) process is set forth, in detail, in the SPP 277 Policy, as such policy may be amended from time to time, and shall be implemented for all:

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

6.9-2 Ongoing Professional Practice Evaluation. Upon conclusion of the FPPE period, ongoing professional practice evaluation (OPPE) shall be conducted on all Practitioners with Privileges. The Hospital's OPPE process is set forth, in detail, in the SPP 277 Policy, as such policy may be amended from time to time, and requires the Hospital to gather, maintain, and review data on the performance of all Practitioners with Privileges on an ongoing basis.

ARTICLE VII:

CORRECTIVE ACTION, SUMMARY SUSPENSION, AUTOMATIC SUSPENSION/TERMINATION

SECTION 7.1. COLLEGIAL INTERVENTION

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

SECTION 7.2. CORRECTIVE ACTION

7.2-1 Grounds for Corrective Action:

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

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

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

c. Disruptive to patient care activities or Hospital operations;

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

e. Below the applicable standard of care; or

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

7.2-2 Authorization to Initiate:

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

a. An officer of the Medical staff.

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

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

d. The Chief Executive Officer.

e. The Board or the Chair thereof.

7.2-3 Requests and Notices:

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

7.2-4 Investigation:

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

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

7.2-5 Medical Executive Committee Action:

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

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

b. A warning;

c. Letter of reprimand;

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

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

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

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

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

7.2-6 Procedural Rights

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

7.2-7 Other Action

If the MEC's recommendation as provided in Section 7.2-5 a, b, c, or d (where such action does not materially restrict a practitioner's exercise of privileges), such recommendation, together with all supporting documentation, shall be transmitted to the Board. The Fair Hearing Plan shall not apply to such actions.

7.2-8 Board Action

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

7.2-9 Additional Action.

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

SECTION 7.3. SUMMARY SUSPENSION

7.3-1 Initiation of Summary Suspension:

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

a. The Chief of Staff

b. The applicable Department Director

c. The CEO of the Hospital

d. The Board or its Chair

e. The MEC

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

7.3-2 MEC Action:

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

7.3-3 Board or CEO Action:

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

7.3-4 Procedural Rights:

Not later than fourteen (14) days following the original imposition of the summary suspension, the Practitioner shall be advised by Special Notice of the MEC's determination or, in the case of a summary suspension imposed by the CEO or Board, of the MEC's recommendation as to whether such suspension should be terminated,

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

SECTION 7.4. AUTOMATIC SUSPENSION OF PRIVILEGES

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

7.4-1 Grounds

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

b. Drug Enforcement Administration (DEA) Number. A Practitioner whose DEA certification/number or equivalent state credential is revoked or suspended or voluntarily relinquished shall immediately and automatically be suspended from the staff and practicing in the Hospital, until such time as the registration is reinstated.

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

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

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

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

7.4-2 Impact of Automatic Suspension/Limitation.

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

7.4-3 Medical Executive Committee Action Following Automatic Suspension.

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

7.4-4 Reinstatement following Automatic Suspension.

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

SECTION 7.5. AUTOMATIC TERMINATION OF PRIVILEGES

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

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

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

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

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

e. Conviction of a Crime. If a Practitioner pleads guilty to, is found guilty of, or pleads no contest to a felony or other serious offense that involves (a) violence or abuse upon a person; (b) conversion, embezzlement, or misappropriation of property; (c) fraud, bribery, evidence tampering, or perjury; or (d) a drug offense, the Practitioner's Medical Staff appointment and Privileges shall be immediately and automatically terminated.

SECTION 7.6. CONTINUITY OF PATIENT CARE

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

ARTICLE VIII:

HEARINGS AND REVIEW

SECTION 8.1. RIGHT TO HEARING

When an adverse action is taken against a Practitioner, the Practitioner shall be entitled to a hearing as described in this Article VIII. An "action" is only taken against a Practitioner if it is (a) a recommendation by the MEC; (b) an action taken by the Board contrary to a favorable recommendation by the MEC; or (c) an action taken by the Board on its own initiative without benefit of a prior recommendation by the MEC. An "action" is only adverse if it is specifically identified as adverse under Section 8.1-1 and not excepted by Section 8.1-2.

8.1-1 Adverse Actions:

The following actions taken against a Practitioner are adverse:

a. Denial of initial appointment or subsequent reappointment to the Medical Staff.

b. Denial of requested advancement in Staff Category based on reasons of quality or professional behavior.

c. Denial of requested Clinical Privileges.

d. Terms of probation resulting in a limitation on previously granted Clinical Privileges for more than thirty (30) days.

e. Application of or change in mandatory consultation requirements on an individual basis resulting in a limitation on previously granted Clinical Privileges for more than thirty (30) days.

f. Suspension of appointment or Clinical Privileges in excess of fourteen (14) days.

g. Termination of Medical Staff appointment or Clinical Privileges.

h. Other recommendations or actions as so designated by the MEC or the Board.

i. Revocation of staff membership.

j. Reduction of staff category due to an adverse determination as to a practitioner's competence or professional conduct.

k. Limitation of the right to admit patients, unless based upon a reduction of staff category not related to an adverse determination as to a practitioner's competence or professional conduct.

l. Reduction of clinical privileges for a period of excess of thirty (30) days.

8.1-2 Actions Which Are Not Adverse:

Notwithstanding the provisions of Section 8.1-1 above, the following actions shall not be considered adverse and shall not constitute grounds for or entitle the Practitioner to a hearing:

a. An oral or written reprimand or warning.

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 8.2. NOTICE OF RIGHTS AND REQUEST FOR A HEARING

8.2-1 Notice:

Upon taking an adverse action against a Practitioner, the Medical Executive Committee or Board, whichever is taking the action, shall notify the Practitioner concerned by Special Notice. The notice shall:

a. contain a statement of the adverse recommendation or action;

b. state the reasons for the adverse recommendation or action;

c. advise the Practitioner that he or she has the right to request a hearing within thirty (30) calendar days of the date of receipt of the notice of the adverse recommendation or action;

d. provide the Practitioner with a summary of the Practitioner's rights at a hearing; and

e. state that if the Practitioner fails to request a hearing in the manner and within the time period prescribed, such failure shall constitute a waiver of the right to a hearing and to an appellate review on the issue that is the subject of the notice.

8.2-2 Request for Hearing:

A Practitioner shall have thirty (30) days after receipt of a notice pursuant to Section 8.2-1 to file a written request for a hearing. Such request shall be delivered to the President & CEO by Special Notice.

8.2-3 Failure to Request a Hearing:

If the Practitioner does not request a hearing within the time or in the manner as provided in Section 8.2-2, the Practitioner shall be deemed to have waived all rights to a hearing and appeal and the adverse recommendation/action shall be submitted to the Board for final decision. The Practitioner shall be informed of the Board's final decision by Special Notice.

SECTION 8.3. PRELIMINARY HEARING PROCEDURES

8.3-1 Notice:

If the Practitioner timely requests a hearing, the MEC or Board (whichever body's action triggered the hearing rights) through the Chief of Staff or the President & CEO,

respectively, shall promptly schedule and arrange for a hearing. A written notice shall be given to the Practitioner, sent by Special Notice, stating the time, date and place of the hearing, which date shall be held not less than thirty (30) days from the date of notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties. The notice shall also state the names of witnesses, if any, expected to testify at the request of the Hospital or Medical Staff and the identity of the Hearing Officer or the Hearing Panel members if then known.

8.3-2 Hearing Officer or Hearing Panel:

A hearing will be conducted by a hearing officer or a hearing panel, as determined in the sole discretion of the Medical Executive Committee or Board, whichever body initiated the adverse action that is the subject of the hearing.

a. Hearing Officer

If a hearing officer is utilized, the individual may be an attorney or may be any of the individuals qualified to sit upon the hearing panel. The hearing officer, if utilized, is appointed by the President & CEO, after consultation with the Chief of Staff or Chairman of the Board, depending on whether the MEC or the Board initiated the adverse action.

b. Hearing Panel

1. If a hearing panel is utilized, the Chief of Staff or President & CEO, depending on whether the MEC or Board initiated the adverse action that is the subject of the hearing, shall appoint two (2) Appointees to sit on the hearing panel. A third member of the hearing panel shall be appointed by the Chief of Staff or President & CEO, whichever did not appoint the first two (2) members. No member of the hearing panel shall be in direct economic competition with the Practitioner requesting the hearing. Appointees may be from any specialty of the Medical Staff regardless of the Practitioner's specialty. The three members of the hearing panel shall elect one (1) of the members to act as the hearing officer to preside at the hearing. In the alternative, the MEC or Board, as appropriate, may appoint an active or retired attorney in addition to the three (3) hearing panel members to act as presiding officer; provided, however, that such individual shall not be entitled to vote on the hearing panel's recommendation.

2. All three (3) members of the hearing panel, if utilized, shall be required to hear the evidence presented at any hearing. Any decision adopted by two (2) members of the panel shall be the decision of the panel.

3. For all other Sections of this Article VIII, the term "Hearing Officer" shall be used for convenience but shall mean either the Hearing Officer (if utilized pursuant to subsection (a)) or the Hearing Panel (if utilized pursuant to subsection (b)).

c. Practitioner Objections to Hearing Officer or Hearing Panel Appointees.

No less than fifteen days prior to the Hearing, the President & CEO shall notify the Practitioner in writing of the names of the Hearing Officer or Hearing Panel, as applicable, and the date by which the Practitioner must object, if at all, to appointment of any members. Any objection to the Hearing Officer or to any member of the Hearing Panel shall be made in writing to the President & CEO with an explanation of the basis for the objection within ten (10) days of receiving notice of the Hearing Officer or Hearing Panel Appointees. After reviewing the objection(s), the President & CEO shall determine, in his or her sole discretion, whether a replacement officer or panel member, as applicable, shall be appointed. While a Practitioner may object to an officer or panel member, the Practitioner may not veto such appointment or participation. Final authority to appoint the officer or panel members, as applicable, rests with the President & CEO.

8.3-3 Disclosure of Information:

a. The Practitioner shall be required to notify the President & CEO by Special Notice, of the identity of witnesses whom the Practitioner intends to call at the hearing not later than ten (10) days prior to the hearing date. The Practitioner shall also submit all documents upon which the Practitioner intends to rely to the President & CEO and the Hearing Officer by Special Notice not less than ten (10) days prior to the hearing.

b. The Medical Executive Committee or Board, as applicable, shall notify the Practitioner by Special Notice, of the identity of witnesses whom the MEC/Board intends to call at the hearing that have not previously been disclosed to the Practitioner not later than ten (10) days prior to the hearing date. The MEC/Board shall also submit all documents upon which the MEC/Board intends to rely to the Practitioner and the Hearing Officer by Special Notice not less than ten (10) days prior to the hearing.

c. Testimony of a witness not disclosed or introduction of evidence not submitted prior to the hearing as provided in this Section shall only be permitted upon discretion of the Hearing Officer upon good cause shown as to why the witness could not have been disclosed or information not have been submitted within the timeframes as required by this Section.

SECTION 8.4. HEARING PROCEDURES

8.4-1 Commencement of Hearing:

The hearing shall commence as scheduled in the notice described in Section 8.3-1 unless the hearing officer, the Practitioner, and the MEC or Board, as applicable, all mutually agree upon a rescheduled date upon which the hearing will be held. If the Practitioner is under suspension the parties shall use their best efforts to cooperate to schedule the hearing as soon as possible provided that the hearing may not be scheduled within the

thirty (30) days after the notice of adverse action unless the Practitioner expressly agrees and waives the right to a later hearing.

8.4-2 Record:

An accurate record of the hearing shall be kept. The mechanism will be established by the MEC or Board, as applicable.

8.4-3 Hearing Rights:

a. Representation

1. The affected Practitioner will be entitled to be accompanied by and/or represented at the hearing by: (1) an Appointee of the Medical Staff in good standing, (2) a member of a local professional society, (3) an attorney, or (4) other individual of the Practitioner's choice.

2. The Medical Executive Committee or Board, as applicable, may also be represented by legal counsel. Further, the Medical Executive Committee or Board, whichever body's action triggered the hearing, will appoint one (1) of its members to represent it at the hearing.

3. Either party may be so represented regardless of whether the other party elects to be represented. Each party shall notify the other of its representative as soon as possible.

b. Presenting Evidence

The affected Practitioner and the Medical Executive Committee or Board, as applicable, shall be permitted to: (1) call and examine witnesses on any matter deemed relevant to the issue of the hearing by the Hearing Officer, and if the Practitioner does not testify in his or her own behalf, he or she may be called and examined as if under cross-examination; (2) cross-examine any witness on any matter deemed relevant to the issue of the hearing by the Hearing Officer; (3) to introduce documents and other evidence deemed relevant to the issue of the hearing by the Hearing Officer and subject to satisfaction of Section 8.3-3; (4) impeach (challenge the credibility of) any witness; (5) rebut any evidence; and (6) at the conclusion of the presentation of evidence by both parties, submit a written statement to the Hearing Officer summarizing the evidence and the party's argument, within time and length limitations set by the Hearing Officer and provided that the party also provides a copy to the opposing party.

c. Record

Each party shall have the right to obtain a copy of the record of the hearing and shall be required to bear reasonable cost for such copy.

8.4-4 Procedure:

a. Presiding at the Hearing

The Hearing Officer will call the hearing to order, preside over the hearing ensure an orderly and efficient proceeding, ensure that all participants in the hearing have a reasonable opportunity to present relevant evidence pursuant to Section 8.4-3(b), and maintain decorum.

b. Order and Burden of Proof

The MEC or Board, as applicable, shall present its case first and the Practitioner shall present his or her case thereafter. It shall be the obligation of the Medical Executive Committee or Board, as applicable, to present appropriate evidence in support of the adverse recommendation or action. The affected Practitioner will thereafter have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacked factual basis or that such basis or any action based thereon is arbitrary, unreasonable, or capricious.

c. Rules

The hearing need not be conducted strictly according to the rules of evidence relating to witnesses or to the presentation of evidence. Any matters upon which responsible persons customarily and reasonably rely in the conduct of serious affairs may be considered regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action, provided that such information is relevant to the issues. The parties may object to evidence prior to or during the hearing, and submit memoranda concerning any issue of procedure or of fact, and such memoranda will become a part of the hearing record.

8.4-5 Recess:

Once the hearing has begun, the Hearing Officer may, upon notice to the parties, recess the hearing and reconvene the same for (a) the purpose of obtaining new or additional evidence or consultation or (b) other good cause.

8.4-6 Adjournment:

Upon conclusion of the presentation of oral and written evidence, the hearing will be closed. The Hearing Officer shall then, at a time in its discretion, conduct its deliberations outside the presence of the parties.

8.4-7 Report:

Within twenty (20) days of the conclusion of the hearing, the Hearing Officer shall render a recommendation, accompanied by a report of its findings, with specific references to the hearing record and other documentation considered, and

a concise statement of the basis for its recommendation(s). The hearing officer recommendation shall be based exclusively upon the written and oral evidence presented at the hearing, and any memoranda submitted by the parties.

SECTION 8.5. DISPOSITION OF HEARING PANEL'S/HEARING OFFICER REPORT

8.5-1 The hearing panel or hearing officer shall deliver its report to the Chief of Staff who, in turn, shall forward it, along with all supporting documentation to the body whose adverse recommendation or action triggered the hearing.

8.5-2 Within fifteen (15) days of receiving the report and recommendation of the hearing panel or hearing officer, the triggering body shall consider the same and affirm, modify, appeal or reverse its recommendation or action in the matter.

a. Favorable Recommendation or Action. When the MEC's recommendation is favorable to the Practitioner, the Board may adopt or reject all or any portion of the MEC's recommendation that was favorable to the Practitioner or refer the matter back to the MEC for additional consideration. Any such referral shall state the reason(s) for the requested reconsideration, set a time limit within which a subsequent recommendation must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take action. A favorable determination by the Board shall be effective as its final decision and the matter shall be considered closed.

b. Adverse Recommendation or Action. If the recommendation of the MEC and/or action of the Board is or continues to be adverse to the affected Practitioner after exhaustion of his/her hearing rights, the Practitioner shall be entitled, upon timely and proper request, to an appellate review before a final decision is rendered on the matter by the Board.

c. Adverse to the MEC. If the hearing panel or hearing officer's recommendation alters the MEC's original recommendation, the MEC shall have the right to either reverse the recommendation, or appeal the recommendation to the Appellate Review Body. The Practitioner shall receive notice of such action as described in Section 8.5-2(d) below.

d. Notice of Hearing Result. Such recommendation or action of the MEC or Board shall be transmitted, together with the hearing record, the report of the hearing panel or hearing officer, and all other documentation considered to the Chief of Staff . The Director of Medical Staff Services shall promptly send a copy of hearing panel's or hearing officer's report, together with a copy of the decision of the body whose adverse recommendation triggered the hearing, to the affected Practitioner by Special Notice. In the event of an adverse result, the notice shall inform the Practitioner of his/her right to request an appellate review by the Board before a final decision regarding the matter is rendered.

SECTION 8.6. APPELLATE REVIEW

8.6-1 Request for Appellate Review/Time for Appeal:

Within ten (10) days after receiving notice of his/her right to request an appellate review, the affected Practitioner may request such review. The request shall be in writing, delivered to the CEO by Special Notice, and include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If the Practitioner wishes an attorney to represent him/her at any appellate review appearance permitted, his/her request for appellate review shall so state. The request shall also state whether the Practitioner wishes to present oral arguments to the appellate review body. If an appeal is not requested in the time and manner specified, the Practitioner's right to such appeal is deemed to be waived, and the Board may take final action.

8.6-2 Grounds for Appeal:

The grounds for appeal shall be limited to the following:

a. There was substantial failure to comply with the Medical Staff Bylaws during the hearing, so as to deny a fair hearing and/or;

b. The Adverse recommendation or action was made arbitrarily or capriciously and/or is not supported by credible evidence.

8.6-3 Time, Place, and Notice:

Upon receipt of a timely and proper request for appellate review, the CEO shall deliver such request to the Board. As soon as practicable, the Board chair shall schedule and arrange for an appellate review. At least ten (10) days prior to the date of the appellate review, the Practitioner shall be given Special Notice of the time, place, and date of the appeal, and whether oral arguments will be permitted. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of the parties involved. An appellate review for a Practitioner who is under a suspension then in effect shall be scheduled as soon as arrangements for it may reasonably be made; provided, the Practitioner agrees to waive the notice requirements. The appellate review body may extend the time for appellate review for good cause if such request is made as soon as is reasonably practicable.

8.6-4 Appellate Review Body:

The Board may conduct the review as a whole or may appoint a subcommittee, composed of three (3) or more members of the Board appointed by the Board chair, to conduct the appeal. If a subcommittee is appointed, one (1) of its members shall be designated as chair by the Board chair. To the extent possible, the appellate review body shall include a Practitioner Board member. If a subcommittee is appointed, it shall prepare a written report and recommendation for the full Board's consideration.

8.6-5 Nature of Appellate Review:

a. The appellate review body shall consider the record of the hearing before the hearing panel/hearing officer, the hearing panel's/hearing officer's report and all subsequent results and actions therefrom. The appellate review body shall also consider any written statements submitted by the parties. The Practitioner shall have access to the records and reports of the hearing panel/hearing officer and the MEC/Board, as applicable, and all other materials, favorable or unfavorable, that were considered in making the Adverse recommendation or taking the Adverse action against the Practitioner.

b. Each party shall have the right to present a written statement in support of its position on appeal. The written statement must be submitted not less than ten (10) days in advance of the date set for appellate review. In its sole discretion, the Board may allow each party or its representative to appear personally and make oral argument not to exceed thirty (30) minutes. The time limits provided in this paragraph may be waived by the appellate review body in its sole discretion.

c. The appellate review body may, at its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the hearing proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the Board.

d. The appellate review body may recess the review proceeding and reconvene the same without additional notice if it deems such recess necessary for the convenience of the participants, to obtain new or additional evidence, or if consultation is required for resolution of the matter Upon conclusion of oral statements, if allowed, the appellate review shall be closed. The review body shall then deliberate outside the presence of the parties at such time and in such location as is convenient to the review body. The appellate review shall be adjourned at the conclusion of the review body's deliberation.

8.6-6 Final Decision of the Board:

Within thirty (30) days after the appellate review is adjourned, the Board shall render a final decision in writing, including specific reasons, and shall send notice thereof to the Practitioner. A copy shall also be provided to the Medical Executive Committee for its information. If a subcommittee heard the appeal, it shall submit its report to the Board within fifteen (15) days of conclusion of the appellate review, and the Board's thirty (30) day time period shall then begin to run.

8.6-7 Further Review:

Except where the matter is referred for further action and recommendation, the final decision of the Board following the appeal shall be effective immediately and shall not be

subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

8.6-8 Right to One Hearing and One Appeal Only:

No Practitioner shall be entitled to more than one (1) hearing and one (1) appellate review on any matter.

8.6-9 Representation by Counsel:

At such time as the Practitioner, MEC, or Board is represented by legal counsel, then all notices required to be sent herein may be served upon the Practitioner or entity's legal counsel, and the requirement that such notices be sent by Special Notice is hereby waived; rather, such notices may be sent by regular U.S. first class mail, telefax, or as otherwise agreed to by the parties.

8.6-10 Reporting:

The CEO shall be responsible for assuring that any reports required to be filed with the Ohio State Medical Board or the National Practitioner Data Bank are filed accurately and in a timely manner.

SECTION 8.7. GENERAL PROVISIONS

8.7-1 The Hospital shall indemnify members of a Hearing Panel from liability arising from acts performed, in accordance with the law, within the scope of their duties on the Hearing Panel.

8.7-2 Applicants and Practitioners who are subject to adverse actions must exhaust all of the remedies provided by these Bylaws, including all of the procedural steps in this Article VIII, prior to initiating legal proceedings.

8.7-3 All hearings and appeals will be closed to all persons not having official business at such hearing or appeal. Any hearing or appeal is part of the peer review process. The Hearing Officer or Hearing Panel, the Medical Executive Committee, and the Board are operating as peer review committees (or agents thereof) when performing the functions of this Article VIII. All participants in any hearing or appeal, including but not limited to the affected Practitioner, must comply with and observe the Ohio peer review privilege.

ARTICLE IX:

OFFICERS OF THE MEDICAL STAFF

SECTION 9.1. OFFICER ENUMERATED

9.1-1 Elected Officers:

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

9.1-2 Appointed Officers:

The appointed officers of the Medical Staff shall be the Director of Credentialing and the Chief Medical Officer.

SECTION 9.2. QUALIFICATIONS

9.2-1 Chief of Staff:

The Chief of Staff must be an Appointee of the Active Staff at the time of nomination and remain so during the term of office. Failure to maintain such status shall immediately create a vacancy in this office. Nominees for Chief of Staff must have been Appointees of the Active Staff for a minimum of four (4) years (inclusive of the Provisional year) by the close of the nominating period, to be eligible for nomination. Nominees for Chief of Staff must have been a member, whether elected or appointed, of the Medical Executive Committee during any period within the last six (6) years prior to the close of the nominating period, and complete a two year term prior to commencement of the Chief of Staff position. Nominees shall be Board Certified or demonstrate a comparable level of experience and competence.

9.2-2 Department Directors:

The Director of Surgery and Director of Medicine shall be Appointees of the Active Staff at the time of nomination and remain so during the term of office. Failure to maintain such status shall immediately create a vacancy in the respective office. Nominees must have been Appointees of the Active Staff for a minimum of three (3) years in their department (inclusive of the Provisional year) by the close of the nominating period, to be eligible for nomination. Nominees shall be Board Certified or demonstrate a comparable level of experience and competence.

9.2-3 Director of Credentialing and Chief Medical Officer:

The Director of Credentialing and Chief Medical Officer shall be appointed by the President & CEO in consultation and with the approval of the elected officers of the Medical Staff. Preference will be given to existing Staff Appointees. In the event an appropriate candidate cannot be identified in the existing Staff, the Directors of Credentialing and Quality Management may be appointed from outside the Staff, subject

to the Practitioner satisfying the eligibility requirements for and obtaining Staff appointment/Privileges. The Director of Credentialing and Chief Medical Officer must remain Appointees of the Active Staff during term of office. Failure to maintain such status shall immediately create a vacancy in the respective office. Nominees shall be Board Certified or demonstrate a comparable level of experience and competence.

SECTION 9.3. ELECTION AND APPOINTMENT OF OFFICERS

9.3-1 Nominating Process:

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

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

9.3-2 Election Process:

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

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

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

9.3-3 Approval:

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

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

9.3-4 MEC:

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

SECTION 9.4. TERMS OF OFFICE

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

SECTION 9.5. REMOVAL OF OFFICERS

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

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

SECTION 9.6. VACANCIES IN MEDICAL STAFF OFFICERS

Vacancies in the elected Medical Staff Officers shall be filled by a qualified Appointee, nominated by the remaining members of the Medical Executive Committee, subject to the approval of: (i) a majority of the voting Staff Appointees present at the next regular Medical Staff meeting that is at least thirty (30) days after the Medical Executive Committee nomination; and (ii) the Board of Trustees. Vacancies in appointed Medical Staff Officers shall be filled promptly by appointment by the President & CEO subject to the approval of the elected Medical Staff Officers.

SECTION 9.7. DUTIES AND FUNCTIONS

9.7-1 Chief of Staff:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.7-2 Department Directors:

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

a. Serve on the Medical Executive Committee.

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

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

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

1. Clinically related activities of the department;

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

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

4. Coordination and integration of interdepartmental and intradepartmental services;

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

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

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

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

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

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

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

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

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

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

15. Maintenance of quality control programs.

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

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

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

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

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

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

9.7-3 Director of Credentialing:

a. Serve on the Medical Executive Committee.

b. Serve as Chair of the Credentials Committee.

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

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

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

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

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

9.7-4 Chief Medical Officer:

a. Serve on the Medical Executive Committee.

b. May assist the Chair in preparing the agenda of the Medical Staff Quality Improvement Committee meetings.

c. Serve as the co-chair of the Quality Outcomes Committee, a Hospital interdisciplinary committee, responsible for organization-wide systems-based performance review activities, including process measurement, assessment, and improvement of clinical and patient care processes.

d. Develop and at least annually review the written policy and procedure for quality management activities for the Medical Staff. This policy and procedure will be presented to the Medical Executive Committee for recommendation to the Board of Trustees.

e. Coordinate all quality management activities performed by the Medical Staff.

f. Integrate Medical Staff quality improvement activities with quality improvement activities performed by Hospital personnel and Hospital committees.

g. Form and oversee ad hoc Medical Staff committees as necessary to investigate specific quality improvement issues.

h. Report all quality improvement activities to the Medical Executive Committee for their review and action.

i. Review of all deaths occurring and all unexpected patient care events and reporting findings to the MEC.

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

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

SECTION 9.8. CONFLICT OF INTEREST OF MEDICAL STAFF MEMBERS

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

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

9.8-3 Upon being granted appointment to the Medical Staff and/or clinical privileges, and upon any grant of reappointment and/or renewal of clinical privileges, each Medical Staff member shall file with the MEC a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a Medical Staff members, and/or a member of the community, which in any way and to any degree may impact on the finances or operations of the Hospital or its staff, or the Hospital's relationship to the community, including but not limited to each of the following:

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

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

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

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

9.8-4 This disclosure requirement is not a punitive process and is only intended to identify those conflicts of interest which may affect patient safety or quality of care. This disclosure requirement is to be construed broadly, and a Medical Staff member should

finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure requirement will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

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

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

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

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

ARTICLE X:

COMMITTEES AND DEPARTMENTS

SECTION 10.1. GENERAL PROVISIONS

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

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

SECTION 10.2. MEDICAL EXECUTIVE COMMITTEE

10.2-1 Composition:

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

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

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

d. Nominees for Members-at-Large must have been Appointees of the Active Staff for a minimum of three (3) years in their department (inclusive of provisional year) to be eligible for election. Nominees shall be board certified or demonstrate

a comparable level of experience and competence. Failure to maintain Active Staff appointment shall immediately create a vacancy in the Member-at-Large position.

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

10.2-2 Meetings:

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

10.2-3 Reports:

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

10.2-4 Duties:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

o. Communicate appropriately to the Medical Staff.

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

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

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

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

SECTION 10.3. MEDICAL QUALITY IMPROVEMENT COMMITTEE

10.3-1 Process:

The Medical Staff Quality Improvement Committee shall act pursuant to the Medical Staff Quality Improvement Committee Peer Review Charter and Policy and Procedure. Recommendations for amendment or repeal of the Medical Staff Quality Improvement Committee Peer Review Policy and Procedure or any provision contained therein may be made to the Board of Trustees after recommendation of the Medical Staff Quality Improvement Committee and the Medical Executive Committee.

10.3-2 Membership:

a. The Medical Staff Quality Improvement Committee shall be a multidisciplinary committee consisting of the Chief Medical Officer and a representative from each of the following specialties: general medicine, a medical subspecialty, family practice, surgery, a surgical subspecialty, Ob/Gyn, emergency medicine, anesthesiology, radiology and pathology. The Chief of Staff, Director of Medicine, Director of Surgery and the Director of Credentialing are ex-officio members without a vote. The MEC members-at-large may be invited as non-voting guests. At no time may more than three Medical Staff Quality Improvement Committee members simultaneously serve on the MEC unless there are vacancies on the MEC resulting from lack of willing participants from the otherwise qualified Medical Staff.

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

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

10.3-3 Meetings:

The Medical Staff Quality Improvement Committee shall meet at least ten times per year at a time and place designated by the Chair. The presence of at least five voting committee members constitutes a quorum for purposes of making case determinations. Action carries upon vote of a majority of voting members present at a meeting at which a quorum is present.

10.3-4 Duties:

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

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

(a) Medical assessment and treatment of patients;

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

(c) Use of medications;

(d) Use of blood and blood components;

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

(f) The use of developed criteria for autopsies.

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

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

4. Effective and efficient use of hospital clinical resources.

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

6. Participation and cooperation with Medical Staff responsibilities.

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

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

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

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

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

4. Implementing changes required to improve performance.

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

SECTION 10.4. CREDENTIALS COMMITTEE

10.4-1 Composition:

The Credentials Committee shall consist of three (3) members including the Director of Credentials appointed by the President & CEO, and two (2) members of the Active Staff appointed by the Chief of Staff and approved by the President & CEO. The two (2) members may not be members of the Medical Executive Committee. Each member,

except the Director of Credentials, will serve a three (3) year term, which shall be staggered so as to always have an experienced member on the Committee.

10.4-2 Meetings:

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

10.4-3 Duties:

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

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

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

SECTION 10.5. OTHER MEDICAL STAFF COMMITTEES

10.5-1 Cancer Committee:

a. Composition

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

b. Chair

The Chair shall be an Appointee in good standing of the Medical Staff at the time of appointment and must remain in good standing during his or her tenure. The Chair shall be qualified by training, and experience, and possess a special interest

in the Hospital Cancer Program. The Chair of the Cancer Committee is appointed by the Chief of Staff. The Chair is responsible for the overall monitoring and evaluation of the committee and reports to the Medical Executive Committee.

c. Meetings

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

d. Objectives:

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

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

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

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

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

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

e. Duties:

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

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

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

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

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

10.5-2 Conflict Resolution Committee

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

10.5-3 Physician Advisors to Hospital Areas:

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

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

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

Radiology Department	Radiologist
Pathology Department	Pathologist
Home Care	Primary Care Physician
Infection Control	Chief Medical Officer
Cancer Program	Oncologist or Surgeon

* *Contracted position: verify individual to contact*

SECTION 10.6. DEPARTMENTS

10.6-1 Description:

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

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

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

10.6-2 Meetings:

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

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

10.6-3 Directors:

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

b. Each Department shall participate in Medical Staff and Hospital activities as described in Section 9.7-2 regarding the duties of the Director.

10.6-4 New Departments:

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

b. Departments or groups of Appointees may submit a request to the MEC for creation of a new Department in a specific area of practice. The MEC shall review such requests and determine whether or not to create such an additional Department. If the MEC determines a new Department should be created, it shall make such recommendation to the Board for final approval. Creation of a new Department shall require approval of the MEC and the Board and require appropriate revisions to the Bylaws.

ARTICLE XI:

MEETINGS

SECTION 11.1. ANNUAL, REGULAR AND SPECIAL

11.1-1 Annual:

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

b. The following order of business shall be observed:

Call to Order

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

11.1-2 Regular Meetings:

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

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

Call to Order

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

11.1-3 Special Meetings:

a. Special meetings of the Medical Staff may be called, from time to time, by the Board, Chief of Staff, the Medical Executive Committee, or on the written

request of any twenty-five percent (25%) of the Active Staff Appointees to Medical Staff. The written request for a special meeting shall be presented to the Chief of Staff, if available, and if not, to the Medical Executive Committee.

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

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

SECTION 11.2. GENERAL PROVISIONS

11.2-1 Notice of Meetings:

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

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

11.2-2 Quorum:

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

a. Action on Bylaws and Rules and Regulations.

Action on the Bylaws and Rules and Regulations shall be pursuant to Section 13.4.1 and Section 13.5.

b. All Other Action.

For all action other than amendments to the Bylaws or Rules and Regulations, the action of a majority of the voting Appointees present, at a meeting at which a quorum exists, shall constitute the action of the Staff or committee. Action may

be taken without a meeting by a committee or the Medical Staff by written ballot. The procedure for action by written ballots shall be the same as set forth above in Section 11.2-3(a), except that the vote may be taken by either anonymous numbered ballots or signed ballots, the total number of signed, returned ballots must at minimum equal one (1) voting Appointee, and means of action is defined as a simple majority of the signed, returned ballots.

11.2-3 Minutes:

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

SECTION 11.3. ATTENDANCE REQUIREMENTS

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

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

11.3-2 Medical Executive Committee:

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

11.3-3 Departments, Hospital Committees:

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

11.3-4 Medical Staff Meetings:

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

ARTICLE XII:

CONFIDENTIALITY, IMMUNITY AND RELEASE

SECTION 12.1. SPECIAL DEFINITIONS

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

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

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

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

SECTION 12.2. AUTHORIZATIONS AND CONDITIONS

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

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

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

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

SECTION 12.3. CONFIDENTIALITY OF INFORMATION

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

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

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

c. reducing morbidity or mortality;

d. contributing to teaching or clinical research

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

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

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

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

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

SECTION 12.4. RELEASE FROM LIABILITY

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

a. For Action Taken:

No Representative or Third Party, as applicable, shall be liable to a Practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as a Representative or Third Party provided that such Representative or Third Party does not act on the basis of false Information knowing such Information to be false.

b. For Gathering/Providing Information:

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

SECTION 12.5. ACTIVITIES AND INFORMATION COVERED

12.5-1 Activities:

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

a. Applications for appointment and Clinical Privileges.

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

c. Focused and Ongoing Professional Practice Evaluations.

d. Professional Review action.

e. Hearings and appellate review.

f. Quality Improvement Activities.

g. Utilization Reviews.

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

12.5-2 Information:

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

SECTION 12.6. RELEASES

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

SECTION 12.7. CUMULATIVE EFFECT

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

ARTICLE XIII:

GENERAL PROVISIONS

SECTION 13.1. COMMUNICATION

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

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

b. The Performance Improvement Department.

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

SECTION 13.2. QUALITY IMPROVEMENT ACTIVITIES

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

SECTION 13.3. RULES AND REGULATIONS AND POLICIES

13.3-1 Rules and Regulations:

a. Medical Staff: Subject to approval by the Board, the Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Staff organizational activities as well as the level of practice required of each Practitioner in the Hospital. Rules and Regulations will be adopted, amended or repealed at any regular or special Medical Staff meeting where a quorum of fifty percent (50%) plus one of those eligible to vote are present, by an affirmative vote of seventy-five percent (75%) by those present and eligible to vote, or as otherwise imposed by the Board. In the event that a quorum does not exist at a meeting at which action or amendment(s) of the Medical Staff Rules and Regulations are proposed, action may thereafter be taken by written ballot pursuant to the procedure set forth in Section 13.5-2 (a).

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

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

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

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

13.3-2 Medical Staff Policies.

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

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

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

SECTION 13.4. FORMULATION OF BYLAWS

13.4-1 Staff Responsibility and Authority:

The Staff may formulate, adopt, and recommend to the Board Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Medical Staff as provided in Section 13.5-2 and by the Board.

13.4-2 Methodology:

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

a. Staff:

1. The affirmative vote of seventy-five percent (75%) of the Staff members eligible to vote on this matter who are present at a meeting at which a quorum exists, provided that the proposed Bylaws and/or alterations, accompanied the notice of the meeting.

2. In the event that a quorum does not exist at a meeting at which action or amendment(s) of the Medical Staff Bylaws or Medical Staff Rules and Regulations are proposed, action may thereafter be taken by written ballot. The written ballots shall be transmitted to all voting Appointees accompanied by the minutes of discussion, if any, concerning the proposed action or amendment(s). The ballot must be submitted to all voting Appointees at least two (2) weeks prior to the close of the voting period, to be established by the Medical Executive Committee. Ballots must be signed by the voting Appointees and signed ballots will be counted only if received by Medical Staff Services by the close of the two (2) week voting period. The total number of signed, returned ballots must at minimum equal a majority of Active Medical Staff voting Appointees. No action shall be effective except upon the affirmative vote of seventy-five (75%) of the signed, returned ballots, assuming a quorum. The Medical Staff Services Manager or designee shall prepare and submit the written ballots to the voting Appointees, receive returned ballots, and transmit the returned ballots to the committee or Medical Staff, as applicable.

b. Board:

The Medical Staff Bylaws may be adopted, amended or repealed by the affirmative vote of two-thirds of the Board after receiving the recommendations of the Medical Staff. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws when necessary to provide for protection of patient welfare or when necessary to comply with accreditation standards or applicable law. However, should the Board act upon its own initiative as provided in this paragraph, it shall consult with the Medical Staff at the next regular staff meeting (or at a special called meeting as provided in these bylaws), and shall advise the staff of the basis for its action in this regard.

c. Review:

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

d. Conflict:

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

e. Minor Technical Amendments:

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

f. No Unilateral Amendment:

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

g. Process

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

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

2. Restating the bylaws, incorporating the approved amendments and all prior approved amendments which have been appended to these bylaws since their last restatement, which restated bylaws shall be dated and signed by the Chief of Staff, the CEO and the Chairperson of the Board of Trustees approved by corporate legal counsel as to form.

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

SECTION 13.5. REVISED MATERIAL

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

SECTION 13.6. MEDICAL STAFF/MEC CONFLICT RESOLUTION

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

SECTION 13.7. APPOINTEE ACTION

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

ADOPTED BY THE MEDICAL STAFF ON November 05, 2019

Rajiv Patel, M.D.
Chief of Staff

Surmeet Bedi, M.D.
Director of Medicine

John Mehnert, D.P.M.
Director of Surgery

APPROVED BY THE BOARD OF TRUSTEES ON December 18, 2019

James Reynolds, Ph.D.
Chairman