COMMUNITY REHABILITATION HOSPITAL NORTH

MEDICAL STAFF BYLAWS

I N D E X

MEDICAL STAFF BYLAWS

OF

COMMUNITY REHABILITATION HOSPITAL NORTH

P R E A M B L E

WHEREAS, Community Rehabilitation Hospital North hereinafter referred to as "Hospital", is operated as an Indiana limited liability company and is not an agency or instrumentality of any state, county or federal government; and

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

WHEREAS, the purpose of this Hospital is to serve as an acute rehabilitation hospital, providing patient care, education, and research; and

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

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

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

NOW, THEREFORE, the Practitioners practicing in Community Rehabilitation Hospital North hereby organize themselves into a Medical Staff conforming to these bylaws.

D E F I N I T I O N S

1. "Active Staff" members shall be those physicians (D.O.s and M.D.s) licensed in the state of Indiana that have the privilege of admitting patients, holding office and voting.

2. “Advanced Practice Professional” (APP) means individuals other than Medical Staff members who is qualified to render direct or indirect medical care under the supervision of a Practitioner who has been afforded privileges within their scope of practice to provide such care in the Hospital. The authority to provide specified patient care services is established by the Medical Staff based on the professional’s qualifications. All APPs are described as Category I, Category II, or Category III practitioners in the Medical Staff Bylaws documents.

3. “Advanced Practice Professional” (APP) Staff” means the formal organization of APPs who are eligible to be granted clinical privileges pursuant to these Bylaws.

4. "Board" and/or “Governing Board” means the Governing Board of the Community Rehabilitation Hospital North.

5. "Board Certification" shall mean certification in one of the Member Boards of the American Board of Medical Specialties (ABMS) or the Bureau of Osteopathic Specialists certifying boards of the American Osteopathic Association (AOA). The National Board of Physicians & Surgeons (NBPAS) may be used for recertification if initial certification was granted by one of the Member Boards of the ABMS or the Bureau of Osteopathic Specialists certifying boards of the AOA. For podiatrists, board certification shall mean certification of the American Board of Podiatric Surgery (ABPS). For dentists, board certification shall mean certification by the American Board of Oral/Maxillofacial Surgeons (ABOMS).

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

7. "Clinical Privileges" means the Board's recognition of an individual’s competence and qualifications to render specific services.

8. "Corporation" means Community Health Network Rehabilitation Hospital, LLC.

9. "Data Bank" means the National Practitioner Data Bank, established pursuant to the Health Care Quality Improvement Act of 1986.

10. “Designee” means one selected by the CEO, President or Vice President to act on his/her behalf with regard to a particular responsibility or activity as permitted by these Bylaws.

11. "Ex-Officio" means service as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.

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

13. “Hospital” mean Community Health Network Rehabilitation Hospital.

14. “Medical Executive Committee" or “MEC” means the Executive Committee of the Medical Staff which shall constitute the governing body of the Medical Staff as described in these Bylaws.

15. "Medical Staff" or “Organized Medical Staff” means all medical osteopathic physicians, and duly licensed dentists and podiatrists who are privileged through the Medical Staff process and who are subject to the Medical Staff Bylaws to attend patients in the Hospital;

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

17. "Medical Staff Year" means January 1 – December 31.

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

19. "Physician" means any person holding a license to practice medicine and/or surgery under an individual with a D.O. or M.D. degree who is properly licensed to practice medicine in Indiana.

20. "Practitioner" means a physician, dentist, or podiatrist who has been granted clinical privileges and/or Medical Staff membership at the Hospital.

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

22. "President" means the member of the Active Medical Staff who is duly elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital or his/her designee.

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

24. “Provider” means physicians, dentists, podiatrists, and APPs with clinical privileges at the Hospital.

25. "Special Notice" means a written notice sent by mail with a return receipt requested or delivered by hand with a written acknowledgment of receipt.

26. “Telehealth” means the use of electronic communication or other communication technologies to provide or support clinical care at a location remote from Hospital.

ARTICLE I - NAME

The name of this organization shall be the Medical Staff of Community Rehabilitation Hospital North.

ARTICLE II - PURPOSES & RESPONSIBILITIES

2.1 PURPOSE

The purposes of the Medical Staff are:

2.1(a) To be the organization through which the benefits of membership on the Medical Staff (mutual education, consultation and professional support) may be obtained and the obligations of staff membership may be fulfilled;

2.1(b) To foster cooperation with administration and the Board while allowing staff members to function with relative freedom in the care and treatment of their patients;

2.1(c) To provide a mechanism to ensure that all patients admitted to or treated in any of the facilities or services of the Hospital shall receive a uniform level of appropriate quality care, treatment and services commensurate with community resources during the length of stay with the organization, by accounting for and reporting regularly to the Board on patient care evaluation, including monitoring and other QAPI (Quality Assessment Performance Improvement) activities in accordance with the Hospital's QAPI program;

2.1(d) To serve as a primary means for accountability to the Board to ensure high quality professional performance of all Practitioners and APPs authorized to practice in the Hospital through delineation of clinical privileges, on-going review and evaluation of each Practitioner's performance in the Hospital, and supervision, review, evaluation and delineation of duties and prerogatives of APPs;

2.1(e) To provide an appropriate educational setting that will promote continuous advancement in professional knowledge and skill.

2.1(f) To promulgate, maintain and enforce bylaws, rules and regulations, and other policies and procedures related to medical care for the proper functioning of the Medical Staff;

2.1(g) To participate in educational activities and scientific research with approved colleges of medicine and dentistry as may be justified by the facilities, personnel, funds or other equipment that are or can be made available;

2.1(h) To assist the Board in identifying changing community health needs and preferences and implement programs to meet those needs and preferences;

2.1(i) To provide a means by which issues concerning the Medical Staff and the Hospital may be discussed with the Board or the CEO; and

2.1(j) To accomplish its goals through appropriate committees and services.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff include:

2.2(a) Accounting for the quality, safety, appropriateness and cost effectiveness of patient care rendered by all Practitioners and APPs authorized to practice in the Hospital, by taking action to:

(1) Assist the Board and CEO and their designees in data compilation, medical record administration, review and evaluation of cost effectiveness and other such functions necessary to meet accreditation and licensure standards, as well as federal and state law requirements;

(2) Define and implement credentialing procedures, including a mechanism for appointment and reappointment and the delineation of clinical privileges and assurance that all individuals with clinical privileges provide services within the scope of individual clinical privileges granted;

(3) Participates in continuing medical education programs addressing issues of QAPI and including the types of care offered by the Hospital;

(4) Implement a utilization management program, based on the requirements of the Hospital's Utilization Management Plan;

(5) Develop an organizational structure that provides continuous monitoring of patient care practices and appropriate supervision of APPs;

(6) Initiate and pursue corrective action with respect to Practitioners and APPs, when warranted;

(7) Develop, administer and enforce these Bylaws, the Rules and Regulations of the staff and other Hospital policies related to medical care;

(8) Review and evaluate the quality and safety of patient care through a valid and reliable patient care monitoring procedure, including identification and resolution of important problems in patient care and treatment; and

(9) Implement a process to identify and manage matters of individual provider health that is separate from the Medical Staff disciplinary function in accordance with the Practitioner Wellness Policy, which is incorporated herein and attached as Appendix "D" hereto.

2.2(b) Maintaining confidentiality with respect to the records and affairs of the Hospital, except as disclosure is authorized by the Board or required by law.

2.3 PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT

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

ARTICLE III - MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Medical Staff membership is a privilege extended by the Hospital and is not a right of any person. Membership on the Medical Staff shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Membership on the Medical Staff shall confer on the Practitioner only such clinical privileges and prerogatives as have been granted by the Board in accordance with these Bylaws. No person shall admit patients to, or provide services to patients in the Hospital, unless he/she has been granted appropriate privileges to do so.

3.2 BASIC QUALIFICATIONS/CONDITIONS OF STAFF MEMBERSHIP

3.2(a) Basic Qualifications

The only people who shall qualify for membership on the Medical Staff are those Practitioners legally licensed in Indiana, who continuously:

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

(2) Are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions, to work cooperatively with others and to be willing to participate in the discharge of staff responsibilities;

(3) Comply and have complied with federal, state and local requirements, if any, for their medical practice, are not and have not been subject to any liability claims, challenges to licensure, or loss of Medical Staff membership or privileges which will adversely affect their services to the Hospital;

(4) Show and maintain current registration with the Drug Enforcement Administration, including the presentment of a DEA number (with the exception of pathologists and any other Provider whose scope of practice does not require a DEA registration/controlled substance certificate, as determined by the MEC and Board);

(5) Have professional liability insurance that meets the requirements of these Bylaws;

(6) Are graduates of an approved educational institution holding appropriate degrees;

(7) Have successfully completed an approved residency program or the equivalent where applicable;

(8) Maintain a good reputation in his/her professional community; have the ability to work successfully with other professionals and have the physical and mental health to adequately practice his/her profession;

(9) Show evidence of the following educational achievements: CME or relevant documentation for additional training specific to their board-certified specialty or the specialty they have been granted privileges to practice at the Hospital. The education should be related to the physician's specialty and to the provision of quality patient care in the Hospital;

(10) Meet one (1) of the following requirements, in addition to those listed above:

(i) Board certification, sufficiently related to the privileges sought and maintained at the Hospital, demonstrated by proof of maintenance; or

(ii) Adequate progress toward Board certification sufficiently related to the privileges sought and maintained at the Hospital. The determination of adequacy shall be made by the MEC and must be approved by the Governing Board; or

The above requirement shall not apply to any Practitioner already a member of the Medical Staff as of Community Rehabilitation Hospital North.

(11) 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; and

(12) Practice in such a manner as not to interfere with the orderly and efficient rendering services by the Hospital or by other Practitioners within the Hospital.

3.2(b) Effects of Other Affiliations

No person shall be automatically entitled to membership on the Medical Staff or to exercise the particular clinical privileges merely because he/she is licensed to practice in this or any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical board, or because he/she had, or presently has, staff membership at this Hospital or at another health care facility or in another practice setting.

3.2(c) Non-Discrimination

No aspect of Medical Staff or APP Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, ethnicity, religion, gender identity, sexual orientation or disability (except as such may impair the Practitioner's ability to provide quality patient care or fulfill his/her duties under these Bylaws), or on the basis of any other criteria unrelated to the delivery of quality patient care in the Hospital, to professional ability and judgment, or to community need.

3.2(d) Ethics

The burden shall be on the applicant to establish that he/she is professionally competent and worthy in character, professional ethics and conduct. Acceptance of membership on the Medical Staff shall constitute the member's certification that he/she has in the past and agrees that he/she will in the future, abide by the lawful principles of Medical Ethics of the American Osteopathic Association, or the American Medical Association, or other applicable codes of ethics.

3.3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each member of the Medical Staff shall:

3.3(a) Provide his/her patients with continuous care at the generally recognized professional level of quality;

3.3(b) Consistent with generally recognized quality standards, deliver patient care in an efficient and financially prudent manner, and adhere to local medical review policies with regard to utilization;

3.3(c) Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff;

3.3(d) Discharge the staff, committee, and Hospital functions for which he/she is responsible by staff category assignment, appointment, election or otherwise;

3.3(e) Cooperate with other members of the Medical Staff, management, the Governing Board and employees of the Hospital;

3.3(f) Adequately prepare and complete in a timely fashion the medical and other required records for all patients he/she admits or, in any way provides care to, in the Hospital;

3.3(g) Adequately enter all orders for treatment within the timeframe required by the applicable Medical Staff Rules, Regulations and Policies using Computerized Physician Order Entry as required by the Rules & Regulations;

3.3(h) Attest that he/she suffers from no health problems which could affect ability to perform the functions of Medical Staff membership and exercise the privileges requested prior to initial exercise of privileges, and participate in the Hospital drug testing program;

3.3(i) Abide by the ethical principles of his/her profession and specialty;

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

3.3(k) Notify the CEO and President immediately if:

(1) His/Her professional licensure in any state is suspended or revoked;

(2) His/Her professional liability insurance is modified or terminated;

(3) He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;

(4) His/Her specialty board certification expires, is voluntarily surrendered, or is revoked;

(5) He/She voluntarily or involuntarily relinquishes his/her licensure to practice any profession in any jurisdiction;

(6) He/She voluntarily or involuntarily relinquishes his/her National Drug Enforcement Agency (DEA) number or state licensure certificate;

(7) His/Her medical staff membership or clinical privileges are voluntarily or involuntarily revoked, reduced, relinquished, limited or restricted in any health care facility;

(8) His/Her patient management is the subject of an investigation by a state medical board;

(9) He/She is excluded from participation in federal or state health insurance; including Medicare or Medicaid;

(10) He/She is currently either voluntarily or involuntarily participating in any rehabilitation or impairment program or has ceased participation in such program without successful completion; or has been diagnosed with any condition resulting in a material change in health status (which would affect an individual's ability to exercise clinical privileges) from the time the individual submitted his/her application;

(11) He/She has any criminal charges, other than minor traffic violations, brought/initiated against him/her; or

(12) He/She is subject to current, pending investigation or challenge to licensure, DEA certification, medical staff membership or clinical privileges at any health care facility, or participation in federal or state insurance.

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.

3.3(l) 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.

3.3(m) Acknowledge and comply with the following standards concerning conflicts of interest:

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.

No Medical Staff member shall use his/her position to obtain or accrue any improper 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.

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 member, 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:

(1) 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 with an entity or facility that competes directly or indirectly with the Hospital;

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

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

(4) Business practices that may adversely affect the Hospital or community.

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.

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 member's written disclosure at the next MEC meeting following filing by the member for review and discussion by the MEC.

3.4 HISTORY & PHYSICAL EXAMINATIONS and INITIAL ASSESSMENT

A medical history and physical examination must be completed and documented by a qualified physician or APP who is credentialed and privileged by the Medical Staff to perform a history and physical examination for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the history and physical shall specifically document the circumstances surrounding the need for additional acute care.

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

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

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

Where required, a history and physical must be completed and documented in accordance with the timeframes described above. The Medical Staff shall recommend, and the Board shall approve, a policy identifying the procedures requiring a history and physical examination as a prerequisite and, if required, the scope of such history and physical. The Medical Staff and Board shall also define via policy any procedures for which an assessment may be conducted and documented in lieu of a comprehensive history and physical examination. Any such assessment in lieu of a comprehensive history and physical examination must be

completed and documented after registration. The assessment must be completed and documented by a qualified physician (or other Practitioner or APP who has been credentialed and granted privileges to perform such assessments).

(1) Patient age, diagnoses, the type and number of procedures scheduled to be performed, and comorbidities.

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

(3) Applicable state and local health and safety laws.

An initial assessment of all patients must be performed by the responsible Medical Staff member within twenty-four (24) hours after admission.

Finally, the History and Physical must include certain rehabilitation specific information such as the following:

(1) Relevant medical/functional changes from the pre-admission screen (PAS);

(2) Identification of the Impairment Group and Etiologic Diagnosis should match the PAS unless there is supporting documentation in the H&P to change one or both; and

(3) Active comorbidities that will be managed with a brief plan to treat each and how the comorbidities may impact the patient's functioning rehab and/or their functional outcome.

Provide a general summary of the Rehab Plan Barriers to discharge estimated LOS, anticipated disposition, and prognosis preliminary and general rehabilitation goals documentation of medical necessity for IRF level care.

If the Rehabilitation Physician wants the H&P to count as one of their three face-to-face visits in week one, they must perform the visit and document the H&P or update. The H&P/update completed by rehabilitation physician should include Current level of functioning.

3.5 DURATION OF APPOINTMENT

3.5(a) Duration of Initial Appointments

All initial appointments to the Medical Staff shall be for a period not to exceed three (3) years. In no case shall the Board take action on an application, refuse to renew an appointment, or cancel an appointment, except as provided for herein. Appointment to the Medical Staff shall confer to the appointee only such privileges as may hereinafter be provided.

3.5(b) Reappointments

Reappointment to the Medical Staff shall be for a period not to exceed three (3) years.

3.5(c) Modification in Staff Category & Clinical Privileges

The MEC may recommend to the Board that a change in staff category of a current staff member or the granting of additional privileges to a current staff member to be made in accordance with the procedures for initial appointment as outlined herein.

3.5(d) Declaration of Moratorium

The Board may from time to time declare moratoriums in the granting or exercising of clinical privileges when the Board, in its discretion, deems such a moratorium to be in the best interest of this Hospital and in the best interest of the health and patient care capable of being provided by the Hospital and its staff. The aforementioned moratoriums may apply to individual medical specialties, or any combination thereof. Prior to declaring a moratorium, the Board will seek the input of the Medical Staff regarding the needs of the Hospital and the patient community.

3.6 LEAVE OF ABSENCE

3.6(a) Leave Status

A staff member may request a voluntary leave of absence from the Medical Staff by submitting a written request to the MEC stating the reason for the leave and the time period of the leave, which may not exceed one (1) year, unless approved by the MEC and Board. If the leave is granted, the Medical Staff member shall not be entitled to exercise any clinical privileges or rights/prerogatives of Medical Staff membership commencing on the date the leave was granted until the Medical Staff member is granted reinstatement. If the staff member's period of appointment ends while the member is on leave, he/she must reapply for Medical Staff membership and clinical privileges. Any such application must be submitted and shall be processed in the manner specified in these Bylaws for applications for initial appointment.

3.6(b) Termination of Leave

(1) At least sixty (60) days prior to the expiration of the leave period, or at any earlier time, the staff member may request reinstatement of his/her privileges by submitting a written notice to that effect to the CEO or his/her designee for transmittal to the MEC. The staff member shall submit a written summary of his/her relevant activities during the leave. The MEC shall make a recommendation to the Board concerning the reinstatement of the member's privileges.

(2) Failure to request reinstatement in a timely manner shall result in automatic termination of staff membership, privileges and prerogatives without right of hearing or appellate review. Termination of Medical Staff membership, privileges and prerogatives pursuant to this section shall not be considered an adverse action. A request for staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified for application for initial appointments.

(3) If a member requests leave of absence for any reason and for any length of time, including but not limited to obtaining further medical training or an armed services commitment the MEC may require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both.

Any new privileges requested will be acted upon and monitored in similar fashion as if the member were a new applicant.

3.7 RESIGNATIONS

Medical Staff or APP Staff members should make a good faith effort to give at least thirty (30) days' notice of a resignation. Resignations must be submitted to the CEO and/or President and shall become effective immediately upon receipt by the CEO and/or President or, if indicated, upon the date indicated by the Medical Staff or APP member in his/her notice. Resignation notices must be signed by the Medical Staff or APP member and may be signed electronically when such notice is provided via email.

ARTICLE IV - CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The Medical Staff shall be divided into "Active" and "Courtesy".

Failure of the applicant to fulfill all of the requirements of appointment relating to meeting attendance, completion of medical records of participation in quality improvement activities may result in relinquishment of staff membership and clinical privileges. By applying for staff membership, the applicant expressly agrees to be bound by these terms, and that any relinquishment by reasons such failure does not afford the applicant any rights under the hearing and appellate review procedures outlined in these Bylaws.

4.2 ACTIVE STAFF

4.2(a) Qualifications

The Active Staff shall consist of Practitioners who:

(1) Meet the basic qualifications set forth in these bylaws;

(2) Have an office and/or residence located within reasonable proximity of the Hospital in order to be continuously available for provision of care to his/her patients, as determined by the Board; and

(3) Regularly admit to, or are otherwise regularly involved in the care of at least twenty-four (24) patients in the Hospital in a calendar year. For purposes of determining whether a Practitioner is "regularly 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; performing visits and H&Ps on patients; interpretation of any inpatient diagnostic procedure or test; or admission or referral of a patient for inpatient care. When a patient has more than one procedure or diagnostic test interpreted by the same Practitioner during a single Hospital stay, the multiple tests for that patient shall count as one (1) patient contact.

4.2(b) Prerogatives

The prerogatives of an Active Staff member shall be:

(1) Eligible to admit patients without limitation, unless otherwise provided in the Medical Staff Bylaws and Rules & Regulations;

(2) To exercise such clinical privileges as are granted to him/her pursuant to Article VII;

(3) To vote on all matters presented at general and special meetings of the Medical Staff;

(4) To vote and hold office in the staff organization and on committees to which he/she is appointed; and

(5) To vote in all Medical Staff elections.

4.2(c) Responsibilities

Each member of the Active Staff shall:

(1) Meet the basic responsibilities set forth in Section 3.3;

(2) Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision;

(3) Actively participate:

(i) in the QAPI program and other patient care evaluation and monitoring activities required of the staff and possess the requisite skill and training for the oversight of care, treatment and services in the Hospital;

(ii) in supervision of other appointees where appropriate;

(iii) in the on-call rotation, as more specifically described in the Medical Staff Rules and Regulations and ***as recommended by the MEC and, approved by the Board*****,** including personal appearance to assess patients when deemed appropriate. Active Staff members have an obligation, but not a right, to share on call duties for the Hospital;

(iii) in promoting effective utilization of resources consistent with delivery of quality patient care; and

(iv) in discharging such other staff functions as may be required from time-to-time.

(4) Serve on at least one (1) Medical Staff committee, if appointed by the President; and

(5) Satisfy the requirements set forth in these bylaws for attendance at meetings of the Medical Staff and of the committees of which he/she is a member.

4.2(d) Failure

Failure to carry out the responsibilities or meet the qualifications as enumerated shall be grounds for corrective action, including, but not limited to, termination of staff membership.

4.3 COURTESY STAFF

4.3(a) Qualifications

The Courtesy Staff shall consist of Practitioners, who:

(1) Meet the basic qualifications set forth in these bylaws;

(2) Have an office and/or residence located within reasonable proximity of the Hospital in order to provide continuous care for a hospitalized patient or arrange to have continuous coverage of these patients by another member of the staff with privileges appropriate to the treatment provided;

(3) Are regularly involved in the care of less than twenty-four (24) patients in a calendar year. Courtesy members who admit or are involved in the care of more than twenty-three (23) patients in a calendar year must transfer to Active Sstaff. The requirement to transfer to Active Staff may be waived by the Board for Practitioners who have their primary practice outside the community and provide services not otherwise available in the community; and

(4) Are members of the Active Staff of another hospital where he/she actively participates in the QAPI program.

4.3(b) Prerogatives

The prerogatives of a Courtesy Staff member shall be to:

(1) Admit patients to the Hospital, if granted the privileges to do so, within the limitations provided in Section 4.3(a);

(2) Exercise such clinical privileges as are granted to him/her pursuant to Article VII;

(3) Attend meetings of the staff and any staff or Hospital education programs; and

(4) Serve on any of the standing committees as a voting member on matters of policies and procedure, except that he/she ***shall not*** be entitled to vote as a member of the MEC or at a general Medical Staff meeting.

4.3(c) Responsibilities

Each member of the Courtesy Staff shall:

(1) Discharge the basic responsibilities specified in Section 3.3;

(2) Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for who he/she is providing service;

(3) Satisfy the requirements set forth in these bylaws for attendance at meetings of the Medical Staff and of the committees of which he/she is a member; and

(4) Take call if there are an inadequate number of Active Staff physicians to provide coverage within a specific specialty. The MEC shall make recommendations to the Governing Board regarding the determination of which specialties require coverage by Courtesy Staff members, and the Board shall have final authority for determining if such requirement of Courtesy Staff members is necessary in order to provide quality care and meet the Hospital's obligations under all applicable state and federal laws.

4.4 RESIDENTS

4.4(a) Qualifications

(1) Residents consist of physicians who are participants in an American Medical Association graduate medical education program approved by the Medical Executive Committee and Governing Board.

(2) Residents shall be credentialed by the residency program in accordance with written affiliation agreements between the Hospital and residency program and in accordance with Hospital policy. In addition, the MEC and Board shall receive information and data from the residency program, consider said information and data, and individually approve each Practitioner prior to any grant of clinical privileges as a Resident. Any decision to not approve a Resident pursuant to an affiliation agreement between the Hospital and residency program shall entitle the affected Practitioner to any grievance procedure rights in the written affiliation agreement between the Hospital and residency program. However, such administrative actions shall not entitle the Resident to any procedural rights pursuant to the Bylaws or Fair Hearing Plan.

4.4(b) Prerogatives

(1) The appropriate director of the residency program shall monitor the clinical and ethical performance of Residents.

(2) Residents shall at all times when performing duties and services at the Hospital be under the direct supervision of a member of the residency program's faculty who shall be a member in good standing on the Active or Courtesy Medical Staff.

(3) Residents may evaluate patients and make entries in the medical record under the supervision of the supervising physician in accordance with Hospital policy.

(4) The supervising physician to whom the Resident has been assigned must be primarily responsible for the care of the patient. It is the responsibility of the supervising physician to document in the progress notes that he has seen the patient and participated in the care of the patient.

(5) Residents shall abide by all provisions of the Medical Staff Bylaws, Rules and Regulations, and Hospital policies and procedures.

(6) Any decision to remove a Resident from service at the Hospital pursuant to an affiliation agreement between the Hospital and residency program shall entitle the affected Practitioner to any grievance procedure rights in the written affiliation agreements between the Hospital and residency program. However, such administrative actions shall not entitle the Resident to any procedural rights pursuant to the Bylaws or the Fair Hearing Plan.

(7) Residents may not hold Medical Staff office. Residents may be allowed to participate in Hospital committees but shall have no voting rights. Residents may attend meetings of the Medical Staff but shall have no voting rights.

4.4(c) Qualifications and Prerogatives of Medical Students

Medical Students shall engage in activity in the Hospital only pursuant to a written affiliation agreement between the Hospital and an approved medical college and only upon express consent of the Medical Executive Committee as reflected in its minutes. Medical students in training at the Hospital shall be permitted to engage in those activities outlined in the medical college affiliation agreement, the Hospital's student manuals, and policies of the Graduate Medical Education Committee. They are not members of the Medical Staff and shall be limited in scope to those activities expressly authorized by the affiliation agreement and any addenda thereto and shall comply with all applicable state and federal laws for their activities within the facility.

4.4(d) Graduate Medical Education Committee

(1) The MEC shall serve as the Graduate Medical Education Committee (GMEC) and shall be responsible for overseeing Residents and Medical Students.

(2) The MEC as the GMEC shall require semiannual updates by the program director regarding academic progress of each Resident and Medical Student. Said report shall include information concerning the safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of, Residents and Medical Students.

(3) The MEC shall report to the Board concerning Residents and Medical Students on at least a semiannual basis. Said report shall include information concerning the safety and quality of patient care, treatment, and services provided by, and the related education and supervisory needs of, Residents and Medical Students.

ARTICLE V - ADVANCED PRACTICE PROFESSIONALS (APP)

5.1 CATEGORIES

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

5.1(a) Category I Practitioner

A type of Advanced Practice Professional who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted.

5.1(b) Category II Practitioner

An Advanced Practice Clinician, a type of Advanced Practice Professional who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising Physician pursuant to a written supervision or collaborative agreement.

5.1(c) Category III Practitioner

A Dependent Practitioner, a type of Advanced Practice Professional who is permitted by law or the Hospital to function only under the direction of a Supervising Physician, pursuant to a written supervision agreement and consistent with the scope of practice granted.

5.2 QUALIFICATIONS

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

5.2(a) APPs must:

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

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

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

(4) Provide a needed service within the Hospital; and

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

5.3 PREROGATIVES

Upon establishing experience, training and current competence, APPs, as identified in Section 5.1, shall have the following prerogatives:

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

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

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

5.4 CONDITIONS OF APPOINTMENT

5.4(a) APPs shall be credentialed in the same manner as outlined in Article VI of the Medical Staff Bylaws for credentialing of Practitioners. Each APP shall be granted clinical privileges relevant to the care provided in the Hospital. The Board in consultation with the MEC shall determine the scope of the activities which each APP may undertake. Such determinations shall be furnished in writing to the APP and shall be final and non-appealable, except as specifically and expressly provided in these bylaws.

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

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

5.4(d) APP privileges shall automatically terminate upon revocation of the privileges of the APP's supervising physician member, unless another qualified physician indicates his/her willingness to supervise the APP and complies with all requirements hereunder for undertaking such supervision. In the event that an APP's supervising physician member's privileges are significantly reduced or restricted, the APP's privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan.

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

5.5 RESPONSIBILITIES

Each APP shall:

5.5(a) Provide his/her patients with continuous care at the generally recognized professional level of quality;

5.5(b) Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff, and personnel policies of the Hospital, if applicable;

5.5(c) Discharge any committee functions for which he/she is responsible;

5.5(d) Cooperate with members of the Medical Staff, APP Staff, administration, the Governing Board and employees of the Hospital;

5.5(e) Adequately prepare and complete in a timely fashion the medical and other required records for which he/she is responsible;

5.5(f) Participate in performance improvement activities and in continuing professional education;

5.5(g) Abide by the ethical principles of his/her profession and specialty; and

5.5(h) Notify the CEO and the President immediately if:

(1) His/Her professional license in any state is suspended or revoked;

(2) His/Her professional liability insurance is modified or terminated;

(3) He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;

(4) His/Her specialty board certification expires, is voluntarily surrendered, or is revoked;

(5) He/She voluntarily or involuntarily relinquishes his/her licensure to practice any profession in any jurisdiction;

(6) He/She voluntarily or involuntarily relinquishes his/her National Drug Enforcement Agency (DEA) number or state licensure certificate;

(7) His/Her APP membership or clinical privileges are voluntarily or involuntarily revoked, reduced, relinquished, limited or restricted in any health care facility;

(8) His/Her patient management is the subject of an investigation by a state medical board;

(9) He/She is excluded from participation in federal or state health insurance; including Medicare or Medicaid;

(10) He/She participates in a voluntary or mandatory drug and/or alcohol rehabilitation program;

(11) He/She has any criminal charges, other than minor traffic violations, brought/initiated against him/her;

(12) He/She is subject to current, pending investigation or challenge to licensure, DEA certification, medical staff membership or clinical privileges at any health care facility, or participation in federal or state insurance; or

(13) He/She ceases to meet any of the standards or requirements set forth herein for continued enjoyment of APP appointment and/or clinical privilege.

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

5.5(i) 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;

5.5(j) Refuse to engage in improper inducements for patient referral; and

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

5.6 CONFLICTS OF INTEREST

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

The best interests of the community, APP Staff and the Hospital are served by APP 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 APP 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 APP Staff for relationships of any APP Staff member which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

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

Upon being granted appointment to the APP Staff and/or clinical privileges and upon any grant of reappointment and/or renewal of clinical privileges, each APP 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 APP Staff member, 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:

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

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

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

(4) Business practices that may adversely affect the Hospital or community.

This disclosure requirement is not a punitive process and is only intended to identify those conflicts of interest which may affect patient safety or quality of care. This disclosure requirement is to be construed broadly, and an APP 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.

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 APP Staff member's written disclosure at the next MEC meeting following filing by the APP Staff member for review and discussion by the MEC.

ARTICLE VI - PROCEDURES FOR APPOINTMENT & REAPPOINTMENT

6.1 GENERAL PROCEDURES

The Medical Staff shall investigate and consider each application for appointment or reappointment to the staff as well as each request for modification of staff membership status and shall adopt and transmit recommendations thereon to the Board. The Board shall be the final authority on granting, extending, terminating or reducing staff membership or clinical privileges. The Board shall be responsible for the final decision as to Medical Staff appointments. A separate, confidential record shall be maintained for each individual requesting Medical Staff membership or clinical privileges.

6.2 CONTENT OF APPLICATION FOR INITIAL APPOINTMENT

Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form approved by the Board, and signed by the applicant. A copy of all active state licenses, current DEA registration/controlled substance certificate (for all Practitioners except pathologists and any other Provider whose scope of practice does not require a DEA registration/controlled substance certificate, as determined by the MEC and Board), a signed Medicare penalty statement and a certificate of insurance must be submitted with the application. The application fee of $300 shall be the responsibility of the applicant. Applicants shall supply the Hospital with all information requested on the application.

The application form shall include, at a minimum, the following:

6.2(a) Acknowledgment & Agreement: A statement that the applicant has received and read the Bylaws, Rules & Regulations and Fair Hearing Plan of the Medical Staff and that he/she agrees:

(1) to be bound by the terms thereof if he/she is granted membership and/or clinical privileges; and

(2) to be bound by the terms thereof in all matters relating to consideration of his/her application, without regard to whether or not he/she is granted membership and/or clinical privileges.

6.2(b) Administrative Remedies: A statement indicating that the Practitioner agrees that he/she will exhaust the administrative remedies afforded by these bylaws before resorting to formal legal action, should an adverse ruling be made with respect to his/her staff membership, staff status, and/or clinical privileges;

6.2(c) Criminal Charges: Any current criminal charges, except minor traffic violations, pending against the applicant and any past convictions or pleas. The Practitioner shall acknowledge the Hospital's right to perform a background check at appointment, reappointment and any interim time when reasonable suspicion has been shown;

6.2(d) Fraud: 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;

6.2(e) Health Status. Evidence of current physical and mental health status only to the extent necessary to demonstrate that the applicant is capable of performing the functions of staff membership and exercising the privileges requested. In instances where there is doubt about an applicants' ability to perform privileges requested, an evaluation by an external or internal source may be requested by the MEC or the Board. Applicant agrees to be bound by the Hospital drug testing policy;

6.2(f) Program Participation: Information concerning the applicant's current participation and/or previous participation in any rehabilitation or impairment program, or termination of participation in such a program without successful completion;

6.2(g) Information on Malpractice Experience: All information concerning malpractice cases against the applicant either filed, pending, settled, or pursued to final judgment. It shall be the continuing duty of the Practitioner to notify the MEC of the initiation of any professional liability action against him/her. The Practitioner shall have a continuing duty to notify the MEC through the CEO or his/her designee within seven (7) days of receiving notice of the initiation of a professional liability action against him/her. The CEO or his/her designee shall be responsible for notifying the MEC of all such actions;

6.2(h) Education: Detailed information concerning the applicant's education and training.

6.2(i) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these bylaws. Each Practitioner must, at all times, keep the CEO informed of changes in his/her professional liability coverage;

6.2(j) Notification of Release and Immunity Provisions: Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity and release provisions;

6.2(k) Professional Sanctions: Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following:

(1) Membership/fellowship in local, state or national professional organizations (excluding voluntary surrender of membership/fellowship while in good standing and while there are no pending investigations or disciplinary proceedings);

(2) Specialty board certifications;

(3) License to practice any profession in any jurisdiction;

(4) Drug Enforcement Agency (DEA) number/controlled substance license for all Practitioners except pathologists and any other Provider whose scope of practice does not require a DEA registration/controlled substance certificate, as determined by the MEC and Board;

(5) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges; or

(6) The Practitioner's management of patients which may have given rise to investigation by the state medical board; or

(7) Participation in any private, federal or state health insurance program, including Medicare or Medicaid.

If any such actions were taken, the particulars thereof shall be obtained before the application is considered complete. The Practitioner shall have a continuing duty to notify the MEC, in writing through the CEO or his/her designee within seven (7) days of receiving notice of the initiation of any of the above actions against him/her. The CEO or his/her designee shall be responsible for notifying the MEC of all such actions.

6.2(l) Qualifications: Detailed information concerning the applicant's experience and qualifications for the requested staff category, including information in satisfaction of the basic qualifications specified in Section 3.2(a), and the applicant's current professional license and federal drug registration numbers;

6.2(m) References: The names of at least three (3) Practitioners (excluding, when feasible, partners, associates in practice, employers, employees or relatives), who have worked with the applicant within the past three (3) years and personally observed his/her professional performance and who are

able to provide knowledgeable peer recommendations as to the applicant's education, relevant training, experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others;

6.2(n) Practice Affiliations: The name and address of all other hospitals, health care organizations or practice settings with whom the applicant is or has previously been affiliated;

6.2(o) Request: Specific requests stating the staff category and specific clinical privileges for which the applicant wishes to be considered;

6.2(p) Identification: A valid state or federal government issued photo identification of the applicant;

6.2(q) Citizenship Status: Proof of United States citizenship or legal residency;

6.2(r) Professional Practice Review Data: For all new applicants and Practitioners requesting new or additional privileges, evidence of the Practitioner's professional practice review, volumes and outcomes from organization(s) that currently privilege the applicant, unless such organization(s) refuse to provide this information to the Hospital, and/or the applicant, after sufficient efforts to obtain the requested information. If the organization(s) refuse to provide the requested information after sufficient efforts, the Hospital must at least obtain case logs specific to the requested privileges for the most recent appointment period from organization(s) that currently privilege the applicant in order to consider the request; and

6.2(s) Continuing Education: Evidence of satisfactory completion of continuing education requirements.

6.3 PROCESSING THE APPLICATION

6.3(a) Request for Application

A Practitioner wishing to be considered for Medical Staff appointment or reappointment and clinical privileges may obtain an application form therefore by submitting his/her written request for an application form to the CEO or his/her designee.

6.3(b) Applicant's Burden

By submitting the application, the applicant:

(1) Signifies his/her willingness to appear for interviews and acknowledges that he/she shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for staff membership and clinical privileges;

(2) Authorizes Hospital representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her current competence and qualifications, and agrees to execute a formal agreement regarding such authorization and release of information upon the Hospital's request;

(3) Consents to the inspection by Hospital representatives of all records and documents that may be material to an evaluation of his/her licensure, specific training, experience, current competence, health status and ability to carry out the clinical privileges he/she requests as well as of his/her professional ethical qualifications for staff membership;

(4) Represents and warrants that all information provided by him/her is true, correct and complete in all material respects, and agrees to notify the Hospital of any change in any of the information furnished in the application;

(5) Acknowledges that, if he/she is determined to have made a material misstatement, misrepresentation, or omission in connection with an application and such misstatement, misrepresentation, or omission is discovered after appointment and/or the granting of clinical privileges, he/she shall have his/her medical staff membership and clinical privileges automatically removed, without fair hearing rights. The determination of materiality shall be in the sole discretion of the MEC and Board;

(6) Pledges to provide continuous care for his/her patients treated in the Hospital; and

(7) Acknowledges that provision of false or misleading information, or omission of information, whether intentional or not, shall be grounds for immediate rejection of his/her application without fair hearing rights.

6.3(c) Statement of Release & Immunity from Liability

The following are express conditions applicable to any applicant and to any person appointed to the Medical Staff or APP Staff and to anyone having or seeking privileges to practice his/her profession in the Hospital during his/her term of appointment or reappointment. In addition, these statements shall be included on the application form, and by applying for appointment, reappointment or clinical privileges the applicant expressly accepts these conditions during the processing and consideration of his/her application, and at all times thereafter, regardless of whether or not he/she is granted appointment or clinical privileges.

I hereby apply for Medical Staff or APP Staff appointment and/or clinical privileges as requested in this application and, whether or not my application is accepted, I acknowledge, consent and agree as follows:

As an applicant for appointment and/or clinical privileges, I have the burden for producing adequate information for proper evaluation of my qualifications. I also agree to update the Hospital with current information regarding all questions contained in this application as such information becomes available and any additional information as may be requested by the Hospital or its authorized representatives. Failure to produce any such information will prevent my application for appointment from being evaluated and acted upon. I hereby signify my willingness to appear for the interview, if requested, in regard to my application.

Information given in or attached to this application is accurate and complete to the best of my knowledge. I fully understand and agree that as a condition to making this application, any misrepresentations or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of appointment and clinical privileges, without fair hearing rights. I further acknowledge that if I am reasonably determined to have made a misstatement, misrepresentation, or omission in connection with an application that is discovered after appointment and/or the granting of clinical privileges, I shall be deemed to have immediately lost my appointment and clinical privileges, without fair hearing rights.

If granted appointment, I accept the following conditions:

(1) I extend immunity to, and release from any and all liability, the Hospital, its authorized representatives and any third parties, as defined in subsection (3) below, for any acts, communications, recommendations or disclosures performed without intentional fraud or malice involving me; performed, made, requested or received by this Hospital and its authorized representatives to, from or by any third party, including otherwise privileged or confidential information, relating, but not limited to, the following:

(i) applications for appointment or clinical privileges, including temporary privileges;

(ii) periodic reappraisals;

(iii) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary action;

(iv) summary suspension;

(v) hearings and appellate reviews;

(vi) medical care evaluations;

(vii) utilization reviews;

(viii) any other Hospital, Medical Staff, or committee activities;

(ix) inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics or behavior; and

(x) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of this or Hospital.

(2) I specifically authorize the Hospital and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics, behavior or other matter bearing on my satisfaction of the criteria for continued appointment to the Medical Staff or APP Staff and/or for the granting of clinical privileges, as well as to inspect or obtain any all communications, reports, records, statements, documents, recommendations and/or disclosure of said third parties relating to such questions. I also specifically authorize said third parties to release said information to the Hospital and its authorized representatives upon request.

(3) The term "Hospital" and "its authorized representatives" means the Hospital Corporation, the Hospital to which I am applying and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application or conduct in the Hospital: the members of the Board and their appointed representatives, the CEO or his/her designees, other Hospital employees, consultants to the Hospital, the Hospital's attorney and his/her partners, associates or designees, and all appointees to the Medical Staff and APP Staff. The term "third parties" means all individuals, including appointees to the Medical Staff and APP Staff, and appointees to the medical staffs or APP staffs of other hospitals or other physicians or Practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives or who have requested such information from the Hospital and its authorized representatives.

I acknowledge that: (1) Medical Staff and APP Staff appointments at this Hospital and clinical privileges are not a right; (2) my request will be evaluated in accordance with prescribed procedures defined in these Bylaws and Rules & Regulations; (3) all Medical Staff recommendations relative to my application are subject to the ultimate action of the Board whose decision shall be final; (4) I have the responsibility to keep this application current by informing the Hospital through the CEO, of any change in the areas of inquiry contained herein; and (5) appointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the acceptable performance of all responsibilities related thereto, as well as other factors that are relevant to the effective and efficient operation of the Hospital.

Appointment and continued clinical privileges shall be granted only on formal application, according to the Hospital and these Bylaws and Rules & Regulations, and upon final approval of the Board.

I understand that before this application will be processed that: (1) I will be provided a copy of the Medical Staff Bylaws and such Hospital policies and directives as are applicable to appointees to the Medical Staff and APP Staff, including these Bylaws and Rules & Regulations of the Medical Staff presently in force; and (2) I must sign a statement acknowledging receipt and an opportunity to read the copies and agreement to abide by all such bylaws, policies, directives and rules and regulations as are in force, and as they may thereafter be amended, during the time I am appointed to the Medical Staff or APP Staff or exercise clinical privileges at the Hospital.

If appointed or granted clinical privileges, I specifically agree to: (1) refrain from fee-splitting or other inducements relating to patient referral; (2) refrain from delegating responsibility for diagnosis or care of hospitalized patient to any other Practitioner or APP who is not qualified to undertake this responsibility or who is not adequately supervised; (3) refrain from deceiving patients as to the identity of any Practitioner or APP providing treatment or services; (4) seek consultation whenever necessary; (5) abide by generally recognized ethical principles applicable to my profession; (6) provide continuous care and supervision as needed to all patients in the Hospital for whom I have responsibility; and (7) accept committee assignment and such other duties and responsibilities as shall be assigned to me by the Board and Medical Staff.

6.3(d) Submission of Application &Verification of Information

Upon completion of the application form and attachment of all required information, the Applicant shall submit the form to the CEO or his/her designee. The application shall be returned to the applicant and shall not be processed further if one (1) or more of the following applies:

(1) Not Licensed. The applicant is not licensed in this state to practice in a field of health care eligible for appointment to the Medical Staff or APP Staff; or

(2) Privileges Denied or Terminated. Within one (1) year immediately preceding the request, the applicant has had his/her application for Medical Staff or APP Staff appointment at this Hospital denied, has resigned his/her Medical Staff or APP Staff appointment at this Hospital during the pendency of an active investigation which could have led to revocation of his/her appointment, or has had his/her appointment revoked or terminated at this Hospital; or had an application rejected as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty; or

(3) Exclusive Contract or Moratorium. The Practitioner practices a specialty which is the subject of a current written exclusive contract for coverage with the Hospital or a moratorium has been imposed by the Board upon acceptance of applications within the applicant's specialty; or

(4) Inadequate Insurance. The Practitioner does not meet the liability insurance coverage requirements of these bylaws; or

(5) Ineligible for Medicare Provider Status. The applicant has been excluded, suspended or debarred from any government payer program or is currently the subject of a pending investigation by any government payer program; or

(6) No DEA Number. The applicant's DEA number/controlled substance license has been revoked or voluntarily relinquished (this section shall not apply to pathologists or telehealth providers); or

(7) Continuous Care Requirement. For applicants who will be seeking advancement to Active or Courtesy Staff, failure to maintain an office or residence within the geographical area required by these bylaws; or

(8) Application Incomplete. The applicant has failed to provide any information required by these bylaws or requested on the application, has provided false or misleading information on the application, or has failed to execute an acknowledgment, agreement or release required by these bylaws or included in the application; or

(9) Felony. The applicant has pleaded guilty or no contest to a felony charge or has been convicted of a felony.

The refusal to further process an application form for any of the above reasons shall not entitle the applicant to any further procedural rights under these bylaws.

In the event that none of the above apply to the application, the CEO or his/her designee, or credentials verification organization ("CVO") pursuant to an agreement with the Hospital, shall promptly seek to collect or verify the references, licensure and other evidence submitted. The CEO or his/her designee shall promptly notify the applicant in writing of any problems in obtaining the information required and it shall then be the applicant's obligation to ensure that the required information is provided within two (2) weeks of receipt of such notification. Verification shall be obtained from primary sources whenever feasible. Licensure shall be verified with the primary source at the time of appointment and initial granting of privileges, at reappointment or renewal or revision of clinical privileges, and at the time of expiration by a letter or computer printout obtained from the appropriate licensing board. Verification of current licensure through the primary source internet site or by telephone is also acceptable so long as verification is documented. When collection and verification are accomplished, the application and all supporting materials shall be transmitted to the Chairperson of the Credentials Committee. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

6.3(e) Description of Initial Clinical Privileges

Medical Staff or APP Staff appointments or reappointments shall not confer any clinical privileges or rights to practice in the Hospital. Each Practitioner or APP who is appointed to the Medical Staff or APP Staff of the Hospital shall be entitled to exercise only those clinical privileges specifically granted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, past performance, demonstrated competence and judgment, references and other relevant information. The applicant shall have the burden of establishing his/her qualifications for, and competence to exercise the clinical privileges he/she requests.

6.3(f) Recommendation of President of the Medical Staff

The President of the Medical Staff shall review the application, the supporting documentation, reports and recommendations, and such other relevant information available to him/her and shall transmit to the Credentials Committee on the prescribed form a written report and recommendation as to staff appointment and, if appointment is recommended, clinical privileges to be granted and any specific conditions to be attached to the appointment. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered. Documentation shall be transmitted with the report.

6.3(g) Credentials Committee Action

Within thirty (30) days of receiving the completed application, the members of the Credentials Committee shall review the application, the supporting documentation, and such other information available as may be relevant to consideration of the applicant's qualifications for the staff category and clinical privileges requested. The Credentials Committee shall transmit to the MEC on the prescribed form a written report and recommendation as to staff appointment and, if appointment is recommended, clinical privileges to be granted and any special conditions to be attached to the appointment. The Credentials Committee also may recommend that the MEC defer action on the application. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered by the committee. Documentation shall be transmitted with the report. Any minority views shall also be in writing, supported by explanation, references and documents, and transmitted with the majority report.

6.3(h) Medical Executive Committee Action

At its next regular meeting after receipt of the Credentials Committee recommendation, but no later than thirty (30) days, the MEC shall consider the recommendation and other relevant information available to it. Where there is doubt about an applicant's ability to perform the privileges requested, the MEC may request an additional evaluation. The MEC shall make specific findings as to the applicant's satisfaction of the requirements of experience, ability, and current competence as set forth in Section 6.3(i). The MEC shall then forward to the Board a written report on the prescribed form concerning staff recommendations and, if appointment is recommended, staff category and clinical privileges to be granted and any special conditions to be attached to the appointment. The MEC also may defer action on the application. The reasons for each recommendation shall be stated and supported by reference to the completed application and other information considered by the committee. Documentation shall be transmitted with the report. Any minority views shall also be reduced to writing, supported by reasons, references and documents, and transmitted with the majority report.

6.3(i) Effect of Medical Executive Committee Action

(1) Deferral: Action by the MEC to defer the complete application for further consideration must be followed up within ninety (90) days with a recommendation for appointment with specified clinical privileges or for rejection of the application. An MEC decision to defer an application shall include specific reference to the reasons therefore and shall describe any additional information needed. If additional information is required from the applicant, he/she shall be so notified, and he/she shall then bear the burden of providing same.

In no event shall the MEC defer action on a completed and verified application for more than ninety (90) days beyond receipt of same.

(2) Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the CEO or his/her designee shall promptly forward it, together with all supporting documentation, to the Board. For purposes of this section, "all supporting documentation" generally shall include the application form and its accompanying information and the report and recommendation of the President. The Board shall act upon the recommendation at its next scheduled meeting, or may defer action if additional information or clarification of existing information is needed, or if verification is not yet complete.

(3) Adverse Recommendation: When the recommendation of the MEC is adverse to the applicant, the CEO or his/her designee shall immediately inform the applicant by special notice which shall specify the reason or reasons for denial and the applicant then shall be entitled to the procedural rights as provided in the Fair Hearing Plan, or for APPs, the procedure outlined in 5.4(b) and 5.4(c). The applicant shall have an opportunity to exercise his/her procedural rights

prior to submission of the adverse recommendation to the Board. For the purpose of this section, an "adverse recommendation" by the MEC is defined as denial of appointment, or denial or restriction of requested clinical privileges. Upon completion of the Fair Hearing process, the Board shall act in the matter as provided in the Fair Hearing Plan, or for APPs, the procedure outlined in 5.4(b) and 5.4(c).

6.3(j) Board Action

(1) Decision; Deadline. The Governing Board may accept, reject or modify the MEC recommendation. The Board may appoint a committee consisting of at least two (2) Board members to review the recommendations received from the MEC. If the committee returns a positive decision concerning the application, the full Board shall ratify that decision at its next regular meeting. If the committee returns a negative decision concerning the application, the application shall be returned to the MEC for further recommendation prior to final action by the Board.

The expedited process may not be used in the following circumstances:

(i) The applicant submits an incomplete application;

(ii) The MEC makes a recommendation that is adverse or with limitation;

(iii) There is a current challenge or a previously successful challenge to licensure or registration;

(iv) The applicant has received an involuntary termination of medical staff or APP staff membership at another organization;

(v) The applicant has received an involuntary limitation, reduction, denial, or loss of clinical privileges; or

(vi) There has been a final judgment adverse to the applicant in a professional liability action.

Any of the above circumstances will require review and consideration by the full Board.

In either case, and in situations in which no committee has been appointed, the Secretary of the Board shall reduce the full Board's decision to writing and shall set forth therein the reasons for the decision. The Board shall make specific findings as to the applicant's satisfaction of the requirements of experience, ability, and current competence as set forth in Section 6.3(l). The written decision shall not disclose any information which is or may be protected from disclosure to the applicant under applicable laws. The Governing Board shall make every reasonable effort to render its decision within ninety (90) days following receipt of the MEC's recommendation.

(2) Favorable Action. In the event that the Governing Boards' decision is favorable to the applicant, such decision shall constitute final action on the application. The CEO or his/her designee shall promptly inform the applicant that his/her application has been granted. The CEO or his/her designee shall also keep each patient care area adequately informed concerning the current clinical privileges granted to each newly approved applicant as well as existing members of the Medical Staff. The decision to grant Medical Staff appointment or reappointment, together with all requested clinical privileges, shall constitute a favorable action even if the exercise of clinical privileges is made contingent upon monitoring, proctoring, periodic drug testing, additional education concurrent with the exercise of clinical privileges, or any similar form of QAPI that does not materially restrict the applicant's ability to exercise the requested clinical privileges.

(3) Adverse Action. In the event that the MEC's recommendation was favorable to the applicant, but the Governing Boards' action is adverse, the applicant shall be entitled to the procedural rights specified in the Fair Hearing Plan, or for APPs, the procedure outlined in 5.4(b) and 5.4(c). The CEO or his/her designee shall immediately deliver to the applicant by special notice, a letter enclosing the Governing Boards' written decision and containing a summary of the applicant's rights as specified in the Fair Hearing Plan, or for APPs, the procedure outlined in 5.4(b) and 5.4(c).

If the Board's action is more restrictive than the MEC's recommendation after the evidentiary hearing, the affected Practitioner may request for a reconsideration of the Board's decision pursuant to the appellate procedure outlined in these Bylaws and the Fair Hearing Plan. Such reconsideration shall be based on the record of the preceding evidentiary hearing.

6.3(k) Interview

An interview may be scheduled with the applicant during any of the steps set out in Section 6.3(f) - 6.3(j). Failure to appear for a requested interview without good cause may be grounds for denial of the application.

6.3(l) Reapplication After Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be considered for appointment to the Medical Staff for a period of one (1) year after notice of such decision is sent, or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. An applicant who has received a final adverse decision as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty shall not be permitted to reapply for a period of five (5) years after notice of the final adverse decision is sent. Notwithstanding anything contained herein, prohibitions on reapplication for a specified period of time may be waived by the Board upon a showing of good cause, provided that the reason for such prohibition is unrelated to professional conduct or competency. Such omission or failure to disclose required information as listed in Section 3.3(k) must be determined by the MEC and Board to have been inadvertent and harmless and must have been remedied to the MEC's satisfaction as promptly as possible after discovery. If the Board decides to not exercise this discretion, the Practitioner is not entitled to the procedural rights outlined in the Fair Hearing Plan.

Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require. For purposes of this section, "final adverse decision" shall include denial after exercise or waiver of fair hearing rights and/or rejection or refusal to further process an application (or relinquishment of privileges) due to the applicant's provision of false or misleading information on, or the omission of information from, or failure to timely update, the application materials.

6.3(m) Time Periods for Processing

Complete applications for staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in this section. The CEO or his/her designee shall transmit a completed application to the Medical Executive Committee upon completing his/her verification tasks, but in any event within ninety (90) days after receiving the completed application, unless the applicant has failed to provide requested information needed to complete the verification process.

6.3(n) Denial for Hospital's Inability to Accommodate Applicant

A decision by the Board to deny 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, or for APPs, the procedure outlined in Sections 5.4(b) and 5.4(c):

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

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

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

However, upon written request of the applicant, the application shall be kept in a pending status for the next succeeding three (3) years. If during this period, the Hospital finds it possible to accept applications for staff positions for which the applicant is eligible, and the Hospital has no obligation to applicants with prior pending status, the CEO or his/her designee shall promptly so inform the applicant of the opportunity by special notice.

Within thirty (30) days of receipt of such notice, the applicant shall provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his/her original application. Thereafter, the procedure provided in Section 6.2 for initial appointment shall apply.

6.3(o) Appointment Considerations

Each recommendation concerning the appointment of a staff member and/or for clinical privileges to be granted shall be based upon an evidence-based assessment of the applicant's experience, ability, and current competence by the Credentials Committee, MEC and Board, including assessment of the applicant's proficiency in areas such as the following:

(1) **Patient Care** with the expectation that Practitioners and APPs provide patient care that is compassionate, appropriate and effective;

(2) **Medical/Clinical Knowledge** of established and evolving biomedical, clinical, and social sciences, and the application of the same to patient care and educating others;

(3) **Practice-Based Learning and Improvement** through demonstrated use and reliance on scientific evidence, adherence to practice guidelines, and evolving use of science, evidence and experience to improve patient care practices;

(4) **Interpersonal and Communication Skills** that enable establishment and maintenance of professional working relationships with patients, patients' families, members of the Medical Staff, Hospital Administration and employees, and others;

(5) **Professional** behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude to patients, the medical profession and society; and

(6) **Systems-Based Practice** reflecting an understanding of the context and systems in which health care is provided.

6.4 REAPPOINTMENT PROCESS

6.4(a) Information Form for Reappointment

At least ninety (90) days prior to the expiration date of a Practitioner or APP's present staff appointment and/or clinical privileges, the CEO or his/her designee shall provide the Practitioner a reapplication form for use in considering reappointment. The Practitioner or APP who desires reappointment and/or renewal of clinical privileges shall, at least sixty (60) days prior to such expiration date, complete the reapplication form by providing updated information with regard to his/her practice during the previous appointment period, and shall forward his/her reapplication form to the CEO or his/her designee. Failure to return a completed application form after two forms have been sent, at least one by certified mail, shall result in automatic termination of membership and clinical privileges at the expiration of the Practitioner or APP's current term.

6.4(b) Content of Reapplication Form

The Reapplication Form shall include, at a minimum, updated information regarding the following:

(1) Education: Continuing training, education, and experience during the preceding appointment period that qualifies the applicant for the privileges sought on reappointment;

(2) License: Current licensure;

(3) Health Status: Current physical and mental health status only to the extent necessary to determine the applicant's ability to perform the functions of staff membership or to exercise the privileges requested;

(4) Program Participation: Information concerning the applicant's current and/or previous participation in any rehabilitation or impairment program, or termination of participation in such a program without successful completion;

(5) Previous Affiliations: The name and address of any other health care organization or practice setting where the applicant provided clinical services during the preceding appointment period;

(6) Professional Sanctions: Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following during the preceding appointment period:

(i) membership/fellowship in local, state or national professional organizations; or

(ii) specialty board certification; or

(iii) license to practice any profession in any jurisdiction; or

(iv) Drug Enforcement Agency (DEA) number/controlled substance license (for all Practitioners except pathologists and any other Provider whose scope of practice does not require a DEA registration/controlled substance certificate, as determined by the MEC and Board; or

(v) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges; or

(vi) the Practitioner's management of patients which may have been given rise to investigation by the state medical board; or

(vii) participation in any private, federal or state health insurance program, including Medicare or Medicaid.

(7) Information on Malpractice Experience: Details about filed, pending, settled, or litigated malpractice claims and suits during the preceding appointment period;

(8) Criminal Charges: Any current criminal charges pending against the applicant, including any federal and/or state criminal convictions related to the delivery of health care, and any convictions or pleas during the preceding appointment period;

(9) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these bylaws. Each Practitioner or APP must, at all times, keep the CEO informed of changes in his/her professional liability coverage;

(10) Current Competency: Objective evidence of the individual's clinical performance, competence, and judgment, based on the findings of evaluations of care and peer evaluations, including, but not limited to an evaluation by the Medical Executive Committee and by one (1) other Medical Staff member who is not a partner, employer, employee or relative of the practitioner or AHP or two (2) Medical Staff members who are not partners, employers or employees, or relatives, and results from the QAPI process of the Medical Staff. Such evidence shall include as the results of the applicant's ongoing practice review, including data comparison to peers, core measures, outcomes, and focused review outcomes during the prior period of appointment. Practitioners and APPs who have not actively practiced in this Hospital during the prior appointment period will have the burden of providing evidence of their professional practice review, volumes and outcomes from organizations that currently privilege them and where they have actively practiced during the prior period of appointment.

Practitioners and APPs who refer their patients to a Hospitalist for inpatient treatment may satisfy this requirement by producing the above information in the form of quality profiles from other facilities where they have actively practiced during the prior appointment period; quality profiles from managed care organizations with whom they have been associated during the prior appointment period, or by submitting relevant medical record documentation from their office or other practice locations that demonstrates current competency for the privileges they are seeking . Practitioners or APPs who refer their patients to a Hospitalist for inpatient treatment shall have a written evaluation from the Hospitalist or Hospitalists treating their patients. The Hospitalist shall provide his/her evaluation of the Practitioner or APP's care based upon consultation and interaction with the Practitioner or APP with regard to the Practitioner or APP's hospitalized patients. The Hospitalist shall provide his/her opinion as to the Practitioner or APP's current competency based upon the condition of the Practitioner or APP's patients upon admission/readmission to the Hospital, with particular emphasis on any readmission related to complications of a previous admission;

(11) Fraud: Any allegations of civil or criminal fraud pending against any applicant and any allegations resolved during the preceding appointment period, as well as any investigations during the preceding appointment period by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid during the preceding appointment period;

(12) Notification of Release & Immunity Provisions: The acknowledgments and statement of release;

(13) Information on Ethics/Qualifications: Such other specific information about the applicant's professional ethics and qualifications that may bear on his/her ability to provide patient care in the Hospital;

(14) References: At the request of the Credentials Committee, the MEC, or the Board, when based on the opinion of the same, there is insufficient data concerning the applicant's exercise of privileges in this Hospital during the preceding term of appointment to base a reasonable evaluation, the names of at least one (1) Practitioner (excluding, when feasible, partners, associates in practice, employers, employees or relatives, as determined by the MEC), who have worked with the applicant within the past two (2) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training and experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others; and

(15) Continuing Education: Evidence of satisfactory completion of continuing education requirements.

6.4(c) Verification of Information

The CEO or his/her designee shall, in timely fashion, verify the additional information made available on each Reapplication Form and collect any other materials or information deemed pertinent, including information regarding the applicant's professional activities, performance and conduct in the Hospital and the query of the Data Bank. Peer recommendations will be collected and considered in the reappointment process. When collection and verification are accomplished, the CEO or his/her designee shall transmit the Reapplication Form and supporting materials to the President. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

6.4(d) Action on Application

The application for reappointment shall thereafter be processed as set forth as described in Section 6.3(d) and 6.3(f) - 6.3(m) for initial appointment; except that an individual whose application for reappointment is denied shall not be permitted to reapply for a period of five (5) years or until the defect constituting the basis for the adverse action is corrected, whichever is later. Notwithstanding the foregoing, denied individuals may be permitted to reapply for appointment before the expiration of five (5) years upon a showing of good cause and provided that the reason for such prohibition is unrelated to professional conduct or competency. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require.

6.4(e) Basis for Recommendations

Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall be based upon an evaluation of the considerations described in this Article VI as they impact upon determinations regarding the applicant's professional performance, ability and clinical judgment in the treatment of patients, his/her discharge of staff obligations, including participation in continuing medical education, his/her compliance with the Medical Staff Bylaws, Rules & Regulations, his/her cooperation with other Practitioners and APPs and with patients, results of the Hospital monitoring and evaluation process, including Practitioner or APP-specific information compared to aggregate information from QAPI activities which consider criteria directly related to quality of care, and other matters bearing on his/her ability and willingness to contribute to quality patient care in the Hospital.

6.5 REQUEST FOR MODIFICATION OF APPOINTMENT

A Provider may, either in connection with reappointment or at any other time, request modification of his/her staff category or clinical privileges, by submitting the request in writing to the CEO. Such request shall be processed in substantially the same manner as provided in Section 6.4 for reappointment. No Provider may

seek modification of privileges or staff category previously denied on initial appointment or reappointment unless supported by documentation of additional training and experience. Notwithstanding the foregoing, a staff member may not request modification of his/her staff category more than once in any two-year appointment term.

6.6 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

6.6(a) Qualifications & Processing

A Practitioner or APP who is providing contract services to the Hospital must meet the same qualifications for membership; must be processed for appointment, reappointment, and clinical privilege delineation in the same manner; must abide by the Medical Staff Bylaws and Rules & Regulations and must fulfill all of the obligations for his/her membership category as any other applicant or staff member.

6.6(b) Requirements for Service

In approving any such Practitioners or APPs for Medical Staff or APP Staff membership, the Medical Staff must require that the services provided meet Joint Commission requirements and CMS Conditions of Participation, are subject to appropriate quality controls, and are evaluated as part of the overall Hospital quality assessment and improvement program.

6.6(c) Termination

Unless otherwise provided in the contract for services, expiration or termination of any exclusive contract for services pursuant to this Section 6.6 or expiration or termination of any provider's employment with the contracting entity, shall automatically result in concurrent termination of Medical Staff or APP Staff membership and clinical privileges. The Fair Hearing Plan does not apply in this case, nor do Sections 5.4(b) or 5.4(c) for APPs.

6.7 CREDENTIALS VERIFICATION ORGANIZATION

Notwithstanding anything in these Bylaws to the contrary, the services of a credentials verification organization (that has been approved by the Board, after consultation with the MEC) ("CVO"), may be utilized in order to meet the credentials verification requirements delineated herein and/or assist in the credentialing process.

ARTICLE VII - DETERMINATION OF CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Every Practitioner or APP providing direct clinical services at this Hospital shall, in connection with such practice and except as provided in Section 7.5, be entitled to exercise only those clinical privileges or services specifically granted to him/her by the Board. Said privileges must be within the scope of the license authorizing the Practitioner or APP 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 APP, and each Practitioner or APP shall bear the burden of establishing his/her qualifications to exercise each individual privilege granted.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2(a) Requests

Each application for appointment and reappointment to the Medical Staff or APP Staff must contain a request for the specific clinical privileges desired by the applicant. The request for specific privileges must be supported by documentation demonstrating the Practitioner or APP's qualifications to exercise the privileges requested. In addition to meeting the general requirements of these Bylaws for Medical Staff or APP Staff membership, each Practitioner or APP 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 or APP for a modification of privileges must be supported by documentation supportive of the request, including at least one (1) peer reference.

7.2(b) Basis for Privileges Determination

Granting of clinical privileges shall be based upon community and Hospital need, available facilities, equipment and number of qualified support personnel and resources as well as on the Practitioner or APP's education, training, current competence, including documented experience treatment areas or procedures; the results of treatment; and the conclusions drawn from QAPI activities, when available. For Practitioners or APPs who have not actively practiced in the Hospital within the prior appointment period, information regarding current competence shall be obtained in the manner outlined in Section 6.4(b)(10) herein. In addition, those Practitioners seeking new, additional or renewed clinical privileges (except those seeking emergency privileges) must meet all criteria for Medical or APP 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 each provider.

7.2(c) Procedure

All requests for clinical privileges shall be evaluated and granted, modified or denied pursuant to the procedures outlined in Article VI and shall be granted for a period not to exceed three (3) years. The Data Bank shall be queried each time new privileges are requested. Any change in the practitioner's privileges shall be communicated to the appropriate parties.

7.2(d) Limitations on Privileges

The delineation of an individual's clinical privileges shall include the limitations, if any, on an individual's prerogatives to admit and treat patients or direct the course of treatment for the conditions for which the patients were admitted.

7.2(e) Initial and Additional Grants of Privileges

All initial appointments and grants of new or additional privileges to existing members of the Medical Staff shall be subject to a period of focused professional practice evaluation. The evaluation period may be renewed and extended for additional periods. Results of the focused professional practice evaluation conducted during the period of appointment shall be incorporated into the Practitioner or APP's evaluation for reappointment. The period of focused professional practice evaluation and any renewal or extension must be approved by the MEC and Board.

7.2(f) Periodic Re-Determination of Clinical Privileges

Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the observation of care provided, review of the records of patients treated in this Hospital or other hospitals and review of the records of the Medical Staff which document the evaluation of the members' participation in the delivery of medical care.

7.3 SPECIAL CONDITIONS FOR DENTAL & PODIATRIC PRIVILEGES

Requests for clinical privileges from dentists, oral surgeons and podiatrists shall be processed, evaluated and granted in the manner specified in Article VI. All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted for other surgical services unless a limited medical appraisal is permitted for the procedure pursuant to Section 3.4 of these bylaws. A physician member of the Medical Staff shall be responsible for admission evaluation, history and physical, and for the care of any medical problem that may be present at the time of admission or that may be discovered during hospitalization, and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

7.4 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS: TEMPORARY PRIVILEGES

7.4(a) Temporary Privileges—Important Patient Care Need—Pending Application

Temporary privileges may be granted when there is an important patient care, treatment, or service need that mandates an immediate authorization to practice, for a limited period of time, to a new applicant with a fully completed, fully verified application that raises no concerns following MEC review and Board approval. "New applicant" includes an individual applying for clinical privileges at the Hospital for the first time and an individual currently holding clinical privileges who is requesting one or more additional privileges.

In these cases only, the Medical Director or his/her designee and the CEO or his/her designee, upon recommendation of the President, may grant such privileges upon establishment of current competence for the privileges requested, completion of the appropriate application, consent, and release, proof of current licensure, DEA certificate, appropriate malpractice insurance, and completion of the required Data Bank query, and upon verification that there are no current or prior successful challenges to licensure or registration, that the Practitioner has not been subject to involuntary termination of Medical Staff membership at another facility, and likewise has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges at another facility. Such privileges may be granted for no more than one hundred and twenty (120) consecutive days of service or one hundred twenty (120) days in a calendar year.

The letter approving temporary privileges shall identify the specific privileges granted. Except as provided above, temporary privileges may not be granted pending processing of applications for appointment or reappointment.

7.4(b) Temporary Privileges—Important Patient Care Need—No Pending Application

Temporary privileges may be granted by the CEO upon recommendation of the President when there is an important patient care, treatment or service need that mandates an immediate authorization to practice, for a limited period of time, when no application for medical staff membership or clinical privileges is pending. An example would be situations in which a physician is involved in an accident or becomes suddenly ill, and a Practitioner is needed to cover his/her practice immediately. Upon receipt of a written request, an appropriately licensed person who is serving as a substitute for a member of the Medical Staff during a period of absence for any reason, or a Practitioner temporarily providing services to cover an important patient care, treatment or service need (which may include care of one (1) specific patient), may, without applying for membership on the staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for one (1) successive consecutive period not to exceed thirty (30) days (for no more than sixty (60) consecutive days), but only upon the Practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in no event to exceed one hundred twenty (120) consecutive days of service or one hundred twenty (120) days within a calendar year. All Practitioners providing coverage for other Practitioners must ensure that all legal requirements, including billing and reimbursement regulations, are met. The Data Bank query must be completed prior to any award of temporary privileges pursuant to this section. Further, prior to award of temporary privileges, due to important patient care need, the applicant must submit a written request for specific privileges and evidence of current competence to perform them, a photograph, proof of appropriate malpractice insurance, the consent and release required by these bylaws, copies of the Practitioner's license to practice medicine, DEA certificate and telephone confirmation of privileges at the Practitioner's primary hospital. The letter approving temporary privileges shall identify the specific privileges granted.

Members of the Medical Staff seeking to facilitate coverage for their practice via a substitute Practitioner shall, where possible, advise the Hospital at least thirty (30) days in advance of the identity of the Practitioner and the dates during which the services will be utilized in order to allow adequate time for appropriate verification to be completed. Failure to do so without good cause shall be grounds for corrective action.

7.4(c) Proctoring Privileges

Upon receipt of a written request, an appropriately licensed person who is serving as a proctor for a member of the Medical Staff may, without applying for membership on the staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for successive periods not to exceed thirty (30) days, but only upon the Practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in no event to exceed the period of proctorship, or a maximum of one hundred twenty (120) consecutive days or one hundred twenty (120) days in a calendar year. The Data Bank query must be completed prior to any award of proctoring privileges pursuant to this section. Further, prior to award of proctoring privileges, the applicant must submit a written request for specific privileges and evidence of current competence to perform them, a photograph, proof of appropriate malpractice insurance, the consent and release required by these bylaws, copies of the Practitioner's license to practice medicine, DEA certificate and confirmation of privileges at the Practitioner's primary hospital. The letter approving proctoring privileges shall identify the specific privileges granted. In these cases only, the CEO or his/her designee, upon recommendation of the President of the Medical Staff, and Chairperson of the Credentials Committee, may grant such privileges upon receipt of the required information.

7.4(d) Conditions

Temporary and proctoring privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting Practitioner or APP's qualifications, ability and judgment to exercise the privileges granted. Special requirements of consultation and reporting may be imposed by the President, including a requirement that the patients of such Practitioner or APP be admitted upon dual admission with a member of the Active Staff. Before temporary, privileges are granted, the Practitioner or APP must acknowledge in writing that he/she has received and read the Medical Staff Bylaws and Rules & Regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her privileges. Temporary privileges may not be granted at the expiration of a staff appointment period absent a documented important/immediate patient care need and in compliance with all other requirements of these Bylaws.

7.4(e) Termination

On the discovery of any information or the occurrence of any event of a professionally questionable nature concerning a Practitioner or APP's qualifications or ability to exercise any or all of the privileges granted, the CEO may, after consultation with the President terminate any or all of such Practitioner or APP's temporary privileges. Where the life or well-being of a patient is endangered by continued treatment by the Practitioner or APP, the termination may be effected by any person entitled to impose summary suspensions under Article VIII, Section 8.2(a). In the event of any such termination, the Practitioner or APP's patients then in the Hospital shall be assigned to another Practitioner or APP by the President. The wishes of the patient shall be considered, if feasible, in choosing a substitute Practitioner or APP.

7.4(f) Rights of the Practitioner

A Practitioner or APP shall not be entitled to the procedural rights afforded by these bylaws because of his/her inability to obtain temporary or proctoring privileges or because of any termination or suspension of such privileges.

7.4(g) Term

No term of temporary or proctoring privileges shall exceed a total of one hundred twenty (120) consecutive days or one hundred twenty (120) days in a calendar year.

7.5 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS: DISASTER PRIVILEGES

A “disaster” for purposes of this section is defined as a community-wide disaster or mass injury situation in which the number of existing, available providers is not adequate to provide all clinical services required by the citizens served by this facility. In the case of a disaster as defined herein, any licensed independent Practitioner, to the degree permitted by his/her license and regardless of staff status or clinical privileges, shall, as approved by the CEO or his/her designee or the President, be permitted to do, and be assisted by Hospital personnel in doing everything reasonable and necessary to save the life of a patient or to treat patients as needed.

Disaster privileges may be granted by the CEO or President when, and for so long as, the Hospital’s emergency management plan has been activated and the Hospital is unable to handle the immediate patient needs. Prior to granting any disaster privileges, the volunteer Practitioner, or licensed independent Practitioner, shall be required to present a valid photo ID issued by a state, federal or regulatory agency, and at least one (1) of the following: a current Hospital picture ID which clearly identifies professional designation; a current license, certification or registration; primary source verification of licensure, certification or registration (if required by law to practice a profession); ID indicating the individual is a

member of a Disaster Medical Assistance Team (DMAT), or the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP); ID indicating the individual has been granted authority to render patient care, treatment, and services in a disaster; or ID of a current medical staff member who possesses personal knowledge regarding the volunteer Practitioner's qualifications. The CEO and/or President are not required to grant such privileges to any individual and shall make such decisions only on a case-by-case basis.

As soon as possible after disaster privileges are granted, but not later than seventy-two (72) hours thereafter, the Practitioner shall undergo the same verification process outlined in Section 7.4(a) for temporary privileges when required to address an emergency patient care need. In extraordinary circumstances in which primary source verification of licensure, certification or registration cannot be completed within seventy-two (72) hours it shall be done as soon as possible, and the Hospital shall document in the emergency/disaster volunteer's credentialing file why primary source verification cannot be performed in the required time frame, the efforts of the Practitioner to continue to provide adequate care, treatment and services, and all attempts to rectify the situation and obtain primary source verification as soon as possible. In all cases, whether or not primary source verification could be obtained within seventy-two (72) hours following the grant of disaster privileges, the President, or his or her designee, shall review the decision to grant the Practitioner disaster privileges, and shall, based on information obtained regarding the professional practice of the Practitioner, make a decision concerning the continuation of the Practitioner's disaster privileges.

In addition, each Practitioner granted disaster privileges shall be issued a Hospital ID (or if not practicable by time or other circumstances to issue official Hospital ID, then another form of identification) that clearly indicates the identity of the Practitioner, and the scope of the Practitioner's disaster responsibilities and/or privileges. A member of the medical staff shall be assigned to each disaster volunteer Practitioner for purposes of overseeing the professional performance of the volunteer Practitioner through such mechanisms as direct observation of care, concurrent or retrospective clinical record review, mentoring, or as otherwise provided in the grant of privileges.

7.6 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS: TELEHEALTH PRIVILEGES

7.6(a) Scope of Privileges

The Medical Staff shall make recommendations to the Governing Board regarding which clinical services are appropriately delivered through the medium of telehealth, and the scope of such services. Clinical services offered through this means shall be provided consistent with commonly accepted quality standards. Physicians applying for clinical privileges to provide treatment to Hospital patients through telehealth shall not be permitted to admit patients or serve as the attending physician.

7.6(b) Telehealth Physicians

Any physician who prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient at the Hospital through a telehealth procedure (the "telehealth physician"), must be credentialed and privileged through the Medical Staff pursuant to the credentialing and privileging procedures described in these Medical Staff Bylaws. An exception is outlined below for those circumstances in which the Practitioner's distant-site entity or distant-site hospital is a Joint Commission accredited organization or a Medicare participating organization, and the Hospital places in the Practitioner's credentialing file a copy of written documentation confirming such accreditation.

In circumstances in which the distant-site entity or hospital is a Joint Commission accredited organization or a Medicare participating organization, the Medical Staff and Board may rely on the telehealth physician's credentialing information from the distant-site entity or distant-hospital to credential and privilege the telehealth physician ONLY if the Hospital has ensured through a written

agreement with the distant-site entity or distant-site hospital that all of the following provisions are met:

(i) The distant-site entity or distant-site hospital meets the requirements of 42 CFR § 482.12(a)(1)-(7), with regard to the distant-site entity's or distant-site hospital's physicians and Practitioners providing telehealth services;

(ii) The distant-site entity, if not a distant-site hospital, is a contractor of services to the Hospital and as such, in accordance with 42 CFR § 482.12(e), furnishes the contracted services in a manner that permits the Hospital to comply with all applicable federal regulations for the contracted services;

(iii) The distant-site organization is either a Medicare-participating hospital or a distant-site telehealth entity with medical staff credentialing and privileging processes and standards that at least meet the standards set forth in the CMS Hospital Conditions of Participation and the Joint Commission Medical Staff (MS) chapter for hospitals or ambulatory care organizations, as applicable;

(iv) The telehealth physician is privileged at the distant-site entity or distant-site hospital providing the telehealth services, and the distant-site entity or distant-site hospital provides the Hospital with a current list of the telehealth physician's privileges at the distant-site entity or distant-site hospital;

(v) The telehealth physician holds a license issued or recognized by the State of Indiana; and

(vi) The Hospital has evidence, or will collect evidence, of an internal review of the telehealth physician's performance of telehealth privileges at the Hospital and shall send the distant-site entity or distant-site hospital such performance information (including, at a minimum, all adverse events that result from telehealth services provided by the telehealth physician and all complaints the Hospital has received about the telehealth physician) for use in the periodic appraisal of the telehealth physician by the distant-site entity or distant-site hospital.

For the purposes of this Section, the term "distant-site entity" shall mean an entity that: (1) provides telehealth services; (2) is not a Medicare-participating hospital; (3) is Joint Commission accredited; and (4) provides contracted services in a manner that enables a hospital using its services to meet all applicable CMS Hospital Conditions of Participation, particularly those related to the credentialing and privileging of physicians providing telehealth services. For the purposes of this Section 7.6, the term "distant-site hospital" shall mean a Medicare-participating and Joint Commission accredited hospital that provides telehealth services.

If the telehealth physician's site is also accredited by Joint Commission, and the telehealth physician is privileged to perform the services and procedures for which privileges are being sought in the Hospital, then the telehealth physician's credentialing information from that site may be relied upon to credential the telehealth physician in the Hospital. However, this Hospital will remain responsible for primary source verification of licensure, professional liability insurance, Medicare/Medicaid eligibility and for the query of the Data Bank.

ARTICLE VIII - CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1(a) Criteria for Initiation

Whenever activities, omissions, or any professional conduct of a Practitioner with clinical privileges are detrimental to patient safety, to the delivery of quality patient care, are disruptive, undermine a culture of safety or interfere with Hospital operations, or violate the provisions of these Bylaws, the Medical Staff Rules and Regulations, or duly adopted policies and procedures; corrective action against such Practitioner may be initiated by any officer of the Medical Staff, by the CEO, or the Board. Procedural guidelines from the Health Care Quality Improvement Act shall be followed in the event of corrective action against a physician or dentist with clinical privileges, and all corrective action shall be taken in good faith in the interest of quality patient care.

8.1(b) Request & Notices

All requests for corrective action under this Section 8.1 shall be submitted in writing to the MEC and supported by reference to the specific activities or conduct which constitute the grounds for the request. The MEC may also initiate corrective action on its own initiative based on information received from other sources. The MEC shall reference the specific activities or conduct constituting the basis of the action. The President shall promptly notify the CEO or his/her designee in writing of all requests for corrective action received by the committee and shall continue to keep the CEO or his/her designee fully informed of all action taken in conjunction therewith.

8.1(c) Investigation by the Medical Executive Committee

The MEC shall begin to investigate the matter within forty-five (45) days or at its next regular meeting whichever is sooner or shall appoint an ad hoc committee to investigate it. When the investigation involves an issue of physician impairment, the MEC shall assign the matter to an ad hoc committee of three (3) members who shall operate apart from this corrective action process, pursuant to the provisions of Hospital's Practitioner Wellness Policy. Within sixty (60) days after the investigation begins, a written report of the investigation shall be completed.

8.1(d) Medical Executive Committee Action

Within sixty (60) days following receipt of the report, the MEC shall take action upon the request. Its action shall be reported in writing and may include, but not limited to:

(1) Rejecting or modifying the request for corrective action;

(2) Recusing itself from the matter and referring same to the Board without recommendation, together with a statement of its reasons for recusing itself from the matter, which reasons may include but are not limited to a conflict of interest due to direct economic competition or economic interdependence with the affected physician;

(3) Issuing a warning, letter of admonition or reprimand to which the Practitioner may write a rebuttal, if he/she so desires;

(4) Recommending terms of probation or required consultation;

(5) Modifying or sustaining an already imposed temporary suspension of clinical privileges;

(6) Recommending reduction, suspension or revocation of clinical privileges;

(7) Recommending reduction of staff category or limitation of any staff prerogatives

(8) Recommending a period of focused professional practice evaluation (FPPE);

(9) Recommending suspension or revocation of staff membership; or

(10) Taking no action.

8.1(e) Procedural Rights

Any action by the MEC pursuant to Section 8.1(d)(4), (5), (6), (7), or (8) (where such action materially restricts a physician's or dentist'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 IX 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.

8.1(f) Other Action

If the MEC's recommended action is as provided in Section 8.1(d)(1), (2), (3), (4), (6) or (7) (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.

8.1(g) Board Action

When routine corrective action is initiated by the Board pursuant to Section 1.2(2) or (3) of the Fair Hearing Plan, the functions assigned to the MEC under this Section 8.1 shall be performed by the Board, and shall entitle the Practitioner to the procedural rights as specified in the Fair Hearing Plan.

If the MEC fails to investigate or to adequately investigate, or to take appropriate disciplinary action, contrary to the weight of the evidence, the Board may direct the MEC to initiate or perform additional investigation or take disciplinary action or additional disciplinary action. If the MEC fails to take appropriate action in response to the Board's direction, the Board may initiate corrective action pursuant to the terms described in this Section 8.1.

8.2 SUMMARY SUSPENSION

8.2(a) Criteria & Initiation

Notwithstanding the provisions of Section 8.1 above, whenever a Practitioner willfully disregards these bylaws or other Hospital policies and such disregard effects patient safety, or his/her conduct may require that immediate action be taken to protect the life, well-being, health or safety of any patient, employee or other person, then the Medical Director, the CEO, or a member of the MEC, or the Governing Board shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges immediately upon imposition. Subsequently, the CEO or his/her designee shall, on behalf of the imposer of such suspension, promptly give special notice of the suspension to the Practitioner.

Immediately upon the imposition of summary suspension, the President shall designate a physician with appropriate clinical privileges to provide continued medical care for the suspended Practitioner's patients still in the Hospital. The wishes of the patient shall be considered, if feasible, in the selection of the assigned physician.

It shall be the duty of all Medical Staff members to cooperate with the President and the CEO in enforcing all suspensions and in caring for the suspended Practitioner's patients.

8.2(b) Medical Executive Committee Action

Within seventy-two (72) hours after such summary suspension, a meeting of the MEC shall be convened to review and consider the action taken. However, if the MEC met as a full body to impose the summary suspension for investigational purposes (for up to fourteen (14) days), the MEC is not required to meet again within seventy-two (72) hours. The MEC may recommend modification, ratification, continuation with further investigation or termination of the summary suspension.

8.2(c) Procedural Rights

If the summary suspension is terminated or modified within fourteen (14) days of the original imposition, such that the Practitioner's privileges are not materially restricted, the matter shall be closed and no further action shall be required.

If the summary suspension is continued for purposes of further investigation the MEC shall reconvene within fourteen (14) days of the original imposition of the summary suspension and shall modify, ratify or terminate the summary suspension.

Upon ratification of the summary suspension or modification which materially restricts the physician's or dentist's clinical privileges, the physician or dentist shall be entitled to the procedural rights provided in Article IX and the Fair Hearing Plan. The terms of the summary suspension as sustained or as modified by the MEC shall remain in effect pending a final decision by the Board.

8.3 AUTOMATIC SUSPENSION

8.3(a) License

A Medical Staff or APP Staff member whose license, certificate, or other legal credential authorizing him/her to practice in Indiana is revoked relinquished, suspended or restricted shall immediately and automatically be suspended from the Medical Staff or APP Staff and practicing in the Hospital. Suspensions based upon revocation, relinquishment, suspension or restriction of license shall require the Practitioner or APP to request reinstatement, rather than automatic reinstatement upon reestablishment of his/her full licensure.

8.3(b) Drug Enforcement Administration (DEA) Registration Number

Any Practitioner or APP (except a pathologist or telehealth provider) whose DEA registration number/controlled substance certificate or equivalent state credential is revoked, suspended, relinquished or expired shall immediately and automatically be suspended from the staff and practicing in the Hospital until such time as the registration is reinstated.

8.3(c) Medical Records

(1) Automatic suspension of a Practitioner or APP's privileges shall be imposed for failure to complete medical records as required by the Medical Staff Bylaws and Rules & Regulations. The suspension shall continue until such records are completed unless the Practitioner or APP satisfies the President that he/she has a justifiable excuse for such omissions.

(2) Medical Records- Expulsion: Any Medical Staff or APP Staff member who accumulates forty-five (45) or more CONSECUTIVE days of automatic suspension under said subsection 8.3(c)(1) shall automatically be excluded from the Medical Staff. Such expulsion shall be effective as of the first day after the forty-fifth (45th) consecutive day of such automatic suspension.

8.3(d) Malpractice Insurance Coverage

Any Practitioner or APP unable to provide proof of current medical malpractice coverage in the amounts prescribed in these bylaws will be automatically suspended until proof of such coverage is provided to the MEC and CEO. If proof cannot be provided within fourteen (14) days, the Practitioner or APP shall be excluded from the medical staff.

8.3(e) Failure to Appear/Cooperate

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

8.3(f) Exclusions/Suspension from Medicare

Any Practitioner or APP who is excluded from the Medicare program or any state government payor program will be automatically suspended. Suspensions based exclusion from the Medicare program or any state government payor program shall require the Practitioner to request reinstatement, rather than automatic reinstatement upon reenrollment in the applicable program.

8.3(g) Contractual Prohibitions

Any Practitioner or APP who is subject to any valid agreement (e.g., a non-compete agreement) that would prevent him/her from practicing at the Hospital, upon discovery of such agreement, shall be immediately and automatically suspended from the staff and practicing at the Hospital. The affected Practitioner or APP shall not be permitted to reapply for membership/clinical privileges unless or until the agreement is terminated or expires.

8.3(h) Automatic Suspension - Fair Hearing Plan Not Applicable

No staff member whose privileges are automatically suspended or terminated under this Section 8.3, shall have the right of hearing or appeal as provided under Article IX of these bylaws. The President shall designate a physician to provide continued medical care for any suspended/terminated Practitioner's or APP's patients. Any automatic suspension of longer than ninety (90) days, unless deferred by the MEC as contemplated in Section 8.3(k), shall result in automatic termination of membership and privileges, without further procedural rights.

8.3(i) Medical Director

It shall be the duty of the Medical Director to cooperate with the CEO in enforcing all automatic suspensions and expulsions and in making necessary reports of same. The CEO or his/her designee shall periodically keep the Medical Director informed of the names of staff members who have been suspended or excluded under Section 8.3.

8.3(j) Felony

Any Practitioner or APP who pleads guilty or no contest or who has been convicted of a felony shall be immediately and automatically suspended from the staff and practicing at the Hospital.

8.3(k) Effect of Automatic Suspension

Notwithstanding the provisions of Section 8.3(c), any Practitioner or APP who has been automatically suspended pursuant to this Section 8.3 for at least ninety (90) consecutive days, shall have his/her staff membership and clinical privileges automatically terminated without any hearing

rights. Any attempt to reapply for membership or privileges at the Hospital shall be processed in accordance with these Bylaws as an initial applicant.

This automatic termination may be deferred for up to ninety (90) days after the initial ninety (90) days suspension upon good cause as determined by the MEC and Board.

8.4 ADMINISTRATIVE REMOVAL FROM LEADERSHIP POSITIONS

The Board may, in its sole discretion, remove any Medical Staff leader from his/her leadership position whenever his/her activities, omissions, or any professional conduct are detrimental to patient safety, to the delivery of quality patient care, are disruptive, undermine a culture of safety or interfere with Hospital operations, or violate the provisions of these Bylaws, the Medical Staff Rules and Regulations, or duly adopted policies and procedures. The Board, in its sole discretion, may also remove any Medical Staff leader from his/her leadership position in the event that he/she is no longer in good standing with the Medical Staff. Any such administrative removal from a leadership position shall not affect the individual's Medical Staff membership or clinical privileges, nor shall it entitle the individual to any grievance or hearing rights.

8.5 CONFIDENTIALITY

To maintain confidentiality, participants in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these bylaws for peer review and corrective action.

8.6 PROTECTION FROM LIABILITY

All members of the Board, the Medical Staff, the APP Staff and Hospital personnel assisting in Medical Staff peer review shall have immunity from any civil liability to the fullest extent permitted by state and federal law when participating in any activity described in Article VII of these bylaws.

8.7 SUMMARY SUPERVISION

Whenever criteria exist for initiating corrective action pursuant to this Article, the Practitioner may be summarily placed under supervision concurrently with the initiation of professional review activities until such time as a final determination is made regarding the Practitioner's privileges. Any of the following shall have the right to impose supervision: President, the Board, and/or CEO.

8.8 REAPPLICATION AFTER ADVERSE ACTION

An applicant who has received a final adverse decision pursuant to Section 8.1 or 8.2 which does not include a specific timeframe shall not be considered for appointment to the Medical Staff for a period of five (5) years after notice of such decision is sent or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the staff or the Board may require.

8.9 WITHDRAWAL AFTER SUBMITTING A COMPLETED APPLICATION

An applicant who withdraws his/her application after it has been deemed complete may not resubmit an application for Medical Staff or APP membership or clinical privileges for one (1) year after the date of withdrawal, unless good cause is shown. The determination of good cause shall be made by the MEC and Board, in their sole discretion.

8.10 FALSE INFORMATION ON APPLICATION

Any Practitioner or APP who, after being granted appointment and/or clinical privileges, is determined to have made a misstatement, misrepresentation, or omission in connection with an application shall be deemed to have immediately terminated his/her appointment and clinical privileges. No Practitioner or APP who is

deemed to have lost his/her appointment and clinical privileges pursuant to this Section 8.8 shall be entitled to the procedural rights under these Bylaws and the Fair Hearing Plan, except that the MEC may, upon written request from the Practitioner or APP, permit the Practitioner or APP to appear before it and present information solely as to the issue of whether the Practitioner or APP made a misstatement, misrepresentation, or omission in connection with his/her application. If such appearance is permitted by the MEC, the MEC shall review the material presented by the Practitioner or APP and render a decision as to whether the finding that he/she made a misstatement, misrepresentation, or omission was reasonable, which MEC decision shall be subject to the approval of the Board.

ARTICLE IX - INTERVIEWS & HEARINGS

9.1 INTERVIEWS

When the MEC or Board is considering initiating an adverse action concerning a Practitioner, it may in its discretion give the Practitioner an interview. The interview shall not constitute a hearing, shall be preliminary in nature and shall not be conducted according to the procedural rules provided with respect to hearings. The Practitioner shall be informed of the general nature of the proposed action and may present information relevant thereto. A summary record of such interview shall be made. No legal or other outside representative shall be permitted to participate for any party.

9.2 HEARINGS

9.2(a) Procedure

Whenever a Practitioner requests a hearing based upon or concerning a specific adverse action as defined in Article I of the Fair Hearing Plan, the hearing shall be conducted in accordance with the procedures set forth in the Fair Hearing Plan and the Health Care Quality Improvement Act.

9.2(b) Exceptions

Neither the issuance of a warning, a request to appear before a committee, a letter of admonition, a letter of reprimand, a recommendation for concurrent monitoring, a denial, termination or reduction of temporary privileges, terms of probation, nor any other actions which do not materially restrict the Practitioner's exercise of clinical privileges, shall give rise to any right to a hearing.

9.3 ADVERSE ACTION AFFECTING APPs

Any adverse actions affecting APPs shall be accomplished in accordance with Section 5.4 of these bylaws.

ARTICLE X - OFFICERS

10.1 OFFICERS OF THE STAFF

10.1(a) Identification

The officers of the staff shall be:

(1) A President elected by the Medical Staff; and
(2) A Vice President elected by the Medical Staff.

The Medical Executive Committee shall, at least, consist of the President of the Medical Staff and the Vice President of the Medical Staff. The Medical Executive Committee may include other practitioners and any other individuals as determined by the organized Medical Staff at a meeting duly called and approved by the Governing Board. The majority of the members of the medical executive committee shall be doctors of medicine or osteopathy. The CEO shall be an ex-officio member of the MEC. Notwithstanding the foregoing, only physician members of the MEC shall have the right to vote on matters presented to the MEC. MEC members who are Medical Staff officers shall be deemed removed form the MEC when they cease to be such officers. Other members of the MEC may be removed from the MEC upon a two-thirds vote of the voting Medical Staff at a meeting duly called for such purpose.

10.1(b) Qualifications

Officers must be members of the Active Medical Staff at the time of appointment and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

10.1(c) Nominations

(1) The Nominating Committee shall consist of the President, the Vice President, and the CEO. This committee shall offer one (1) or more nominees for each office to the Medical Staff thirty (30) days before the annual meeting.

(2) Nominations may also be made from the floor at the time of the annual meeting or by petition filed prior to the annual meeting signed by at least ten percent (10%) of the appointees of the Active Staff, with a signed statement of willingness to serve by the nominee, filed with the President at least thirty (30) days before the annual meeting.

10.1(d) Election

Officers shall be elected at the annual meeting of the staff and when otherwise necessary to fill vacancies. Only members of the Active Staff who are present at the annual meeting shall be eligible to vote. Voting may be open or by secret written ballot, as determined by the members present and voting at the meeting. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of all the valid ballots cast, subject to approval by the Governing Board, which approval may be withheld only for good cause.

10.1(e) Removal

(1) Any officer of the Medical Staff may be removed from office upon recommendation of two-thirds of the MEC, and approval of this recommendation by the Governing Board. Any action regarding a reduction, suspension, or elimination of clinical privileges of such officer(s) shall follow the procedures as defined in these Bylaws.

(2) Any practitioner whose engagement by the Hospital requires membership on the Medical Staff shall not have his/her Medical Staff membership or admitting and clinical privileges terminated without the same fair hearing provisions as must be provided for any other member of the Medical Staff, unless otherwise agreed to in the engagement contract.

(3) Any decision regarding termination of a Medical Staff member in a medico-administrative position will be made by the Governing Board. Any decision regarding suspension of clinical privileges of this person shall follow the procedures as defined in these bylaws unless otherwise stated on the engagement contract.

10.1(f) Term of Elected Officers

Each officer shall serve a three (3) year term, commencing on the first day of the Medical Staff year following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected, unless he/she shall sooner resign or be removed from office.

10.1(g) Vacancies in Elected Office

Vacancies in office, other than the President, shall be filled by the MEC until such time as an election can be held. If there is a vacancy in the office of the President, the Vice-President shall serve out the remaining term.

10.1(h) Duties of Elected Officers

(1) President of the Medical Staff. The President shall serve as the principal official of the staff. As such he/she will:

(i) Act in coordination and cooperation with the CEO in all matters of mutual concern within the Hospital;

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

(iii) Serve as the Chairman of the CQPI Committee;

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

(v) Appoint physician liaisons to all functional administrative and clinical areas;

(vi) Represent the views, policies, needs and grievances of the Medical Staff and report to the Governing Board and to the CEO;

(vii) Receive, and interpret the policies of the Governing Board to the Medical Staff and report to the Governing Board on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;

(viii) Be responsible for the educational activities of the Medical Staff; and

(ix) Be the spokesperson for the Medical Staff in its external professional and public relations.

(2) Vice President of the Medical Staff: The Vice President shall be a member of the MEC. In the absence of the President, he/she shall assume all the duties and have the authority of the President. He/She shall perform such additional duties as may be assigned to him/her by the President, the MEC or the Board. Further, the Vice President shall automatically succeed the President for the unexpired portion of the President's term of office if the President shall cease to serve for any reason.

10.1(i) Conflict of Interest of Medical Staff Leaders

The best interest of the community, Medical Staff and the Hospital are served by Medical Staff leaders (defined as any member of the Medical Executive Committee, , officer of the Medical Staff, and/or members of the Medical Staff who are also members of the Hospital's Governing Board) 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 leader which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

No Medical Staff leader shall use his/her position to obtain or accrue any benefit. All Medical Staff leaders 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.

Annually, on or before December 31st, each Medical Staff leader 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 leader, 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:

(1) 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 member of the governing body, executive committee, or service or department chairmanship with an entity or facility that competes directly or indirectly with the Hospital;

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

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

(4) Business practices that may adversely affect the hospital or community.

A new Medical Staff leader shall file the written statement immediately upon being elected or appointed to his/her leadership position. This disclosure requirement is to be construed broadly, and a Medical Staff leader 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 procedure 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.

Between annual 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 member's written disclosure at the next MEC meeting following filing by the member for review and discussion by the MEC.

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 Governing Board. This prohibition may be waived by the Governing Board, in its sole discretion, for good cause shown.

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. A breach of these provisions is deemed sufficient grounds for removal from office of a breaching member by the remaining members of the MEC or the Board on majority vote.

ARTICLE XI - COMMITTEES & FUNCTIONS

11.1 GENERAL PROVISIONS

11.1(a) The Standing Committees and the functions of the Medical Staff are set forth below. The MEC shall appoint special or ad hoc committees to perform functions that are not within the stated functions of one (1) of the standing committees.

11.1(b) Each committee shall keep a permanent record of its proceedings and actions. All committee actions shall be reported to the MEC.

11.1(c) All information pertaining to activities performed by the Medical Staff and its committees and s shall be privileged and confidential to the full extent provided by law.

11.1(d) The CEO or his/her designee shall serve as an ex-officio member, without vote, of each standing and special Medical Staff committee.

11.2 MEDICAL EXECUTIVE COMMITTEE

11.2(a) Members

The Medical Executive Committee shall, at least, consist of:Members of the committee shall include the following:

(1) The President elected by the Medical Staff, Chairman; and
(2) The Vice President elected by the Medical Staff.

The Medical Executive Committee may include other practitioners and any other individuals as determined by the organized Medical Staff at a meeting duly called and approved by the Governing Board. Notwithstanding the foregoing, only physician members of the MEC shall have the right to vote on matters presented to the MEC. MEC members who are Medical Staff officers shall be deemed removed from the MEC when they cease to be such officers. Other members of the MEC may be removed from the MEC upon a two-thirds vote of the voting Medical Staff at a meeting duly called for such purpose.

11.2(b) Functions

The committee shall be responsible for governance of the Medical Staff, shall serve as a liaison mechanism between the Medical Staff, Hospital administration and the Board and shall be empowered to act for the Medical Staff in the intervals between Medical Staff meetings, within the scope of its responsibilities as defined below. All Active Medical Staff members shall be eligible to serve on the MEC. The authority of the MEC is outlined in this Section 12.2(b) and additional functions may be delegated or removed through amendment of this Section 12.2(b). The functions and responsibilities of the MEC shall include, at least the following:

(1) Receiving and acting upon committee reports;

(2) Implementing the approved policies of the Medical Staff;

(3) Recommending to the Board all matters relating to appointments and reappointments, the delineation of clinical privileges, staff category and corrective action;

(4) Fulfilling the Medical Staff's accountability to the Board for the quality and safety of the overall medical care rendered to the patients in the Hospital;

(5) Initiating and pursuing corrective action when warranted, in accordance with Medical Staff Bylaws provisions;

(6) Assuring regular reporting of QAPI and other staff issues to the MEC and to the Governing Board and communicating findings, conclusions, recommendations and actions to improve performance to the Board and appropriate staff members;

(7) Assuring an annual evaluation of the effectiveness of the Hospital's QAPI program is conducted;

(8) Developing and monitoring compliance with these bylaws, the rules and regulations, policies and other Hospital standards;

(9) Recommending action to the CEO on matters of a medico-administrative nature;

(10) Developing and implementing programs to inform the staff about provider health and recognition of illness and impairment in physicians, and addressing prevention of physical, emotional and psychological illness;

(11) Requesting evaluation of Practitioners in instances where there is doubt about a Practitioner's ability to perform the privileges requested. Initiating an investigation of any incident, course of conduct, or allegation indicating that a Practitioner on the Medical Staff may not be complying with the bylaws, may be rendering care below the standards established for Practitioners on the Medical Staff, or may otherwise not be qualified for continued enjoyment of Medical Staff appointment or clinical privileges without limitation, further training, or other safeguard;

(12) Making recommendations to the Board regarding the Medical Staff structure and the mechanisms for review of credentials and delineation of privileges, fair hearing procedures and the mechanism by which Medical Staff membership may be terminated;

(13) Developing and implementing programs for continuing medical education for the Medical Staff;

(14) Evaluating areas of risk in the clinical aspects of patient care and safety and proposing plans and recommendations for reducing these risks;

(15) Informing the Medical Staff of Joint Commission and other accreditation programs and the accreditation status of the Hospital; and

(16) Participating in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs.

11.2(c) <u>Meetings</u>

(1) The MEC shall meet as needed, but at least annually and maintain a permanent record of its proceedings and actions. The date and time will be set by the President of the Medical Staff. The Medical Staff will be given at least two weeks' notice of event.

(2) Minutes for these meetings will be taken and stored electronically as well as in a binder in the administration offices.

(3) A majority of voting members of the MEC must be present to conduct business.

11.2(d) Special Meeting of the Medical Executive Committee

A special meeting of the MEC may be called by the President, when a quorum of the MEC can be convened.

11.2(e) Removal of MEC Members

All members of the MEC shall be removed in accordance with the provisions governing removal from their respective Medical Staff leadership positions. Officers of the Medical Staff who are ex-officio members of the MEC shall be removed in accordance with the procedures described in Section 10.1(e). Ex-officio members of the MEC shall be removed in accordance with the procedures described in Section 11.4(a).

11.3 MEDICAL STAFF FUNCTIONS

11.3(a) Composition of Committees

The MEC shall designate appropriate Medical Staff committees to perform the functions of the Medical Staff.

11.3(b) Functions

The functions of the staff are to:

(1) Monitor, evaluate and improve care provided in and develop clinical policy for all areas, including special care areas;

(2) Conduct or coordinate appropriate QAPI reviews, including review of drug usage, medical record, core measures and other appropriate reviews;

(3) Conduct or coordinate utilization review activities;

(4) Assist the Hospital in providing continuing education opportunities responsive to QAPI activities, new state-of-the-art developments, services provided within the Hospital and other perceived needs and supervise Hospital's professional library services;

(5) Develop and maintain surveillance over drug utilization policies and practices;

(6) Provide for appropriate physician involvement in and approval of the inter-disciplinary plan of care, and provide a mechanism to coordinate the care provided by members of the Medical Staff with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services;

(7) Ensure that when the findings of assessment processes are relevant to an individual's performance, the Medical Staff determines their use in peer review or the ongoing evaluation of a Practitioner's competence;

(8) Investigate and control nosocomial infections and monitor the Hospital's infection control program;

(9) Plan for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community;

(10) Direct staff organizational activities, including staff bylaws, review and revision, staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation;

(11) Provide as part of the Hospital and Medical Staff's obligation to protect patients and others in the organization from harm, the Medical Staff has adopted an Impaired Practitioner Policy;

(12) Ensure that the Medical Staff provides leadership for process measurement, assessment and improvement for the following processes which are dependent on the activities of individuals with clinical privileges:

(i) medical assessment and treatment of patients;

(ii) use of medications, use of blood and blood components;

(iii) use of procedure(s);

(iv) efficiency of clinical practice patterns; and

(v) significant departure from established patterns of clinical practice.

(13) Ensure that the Medical Staff participates in the measurement, assessment and improvement of other patient care processes, including, but not limited to, those related to:

(i) education of patients and families;

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

(iii) accurate, timely and legible completion of patients' medical records including history and physicals;

(iv) patient satisfaction;

(v) sentinel events; and

(vi) patient safety.

(14) Recommend to the Board policies and procedures that define the trends, indications, deviated expectations or outcomes, or concerns that trigger a focused review of a Practitioner's performance and evaluation of a Practitioner's performance by peers;

(15) Make recommendations to the Board regarding the Medical Staff Bylaws, Rules & Regulations, and review same on a regular basis;

(16) Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for membership and delineation of clinical privileges;

(17) Review, on a periodic basis, professional practice evaluations and applications for reappointment including information regarding the competence of staff members; and as a result of such reviews make recommendations for the granting of privileges and reappointments;

(18) Investigate any breach of ethics that is reported to it;

(19) Review APP appeals of adverse privilege determinations; and

(20) To prepare and recommend a slate of nominees for the officers of the Medical Staff.

11.3(c) Execution of Functions

These functions shall be performed by committees of the Medical Staff as required by state and federal regulatory requirements, accrediting agencies and as deemed appropriate by the MEC and the Board.

11.4 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 Organized Medical Staff who are selected by the Medical Executive Committee (and may or may not be members of the Board), two non-physician Board members who are selected by the Board Chair, and the CEO. The CNO shall serve as an non-voting, ex-officio member of the Committee whose presence or absence will not be considered in determining a quorum. 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 care. The process of resolving such a conflict would be as follows:

(1) The conflict or unresolved issue shall be articulated in writing for consideration in the form of a petition to the MEC.

(2) At least 25% of the voting members of the Medical Staff must sign the petition stating the basis for the conflict or disagreement with the action taken or the decision made by the MEC.

(3) Within 30 days of receipt of the petition form the Medical Staff, a meeting between two representatives of the MEC, as appointed by the President, and two of the Medical Staff representatives of the petitioners (as selected by the petitioners) shall be held.

(4) The MEC representatives and the petitioners' representatives shall discuss the issues set forth in good faith, in an attempt to resolve the conflict or disagreement in the best interests of promoting safety and high quality of care.

(5) If the representatives of the MEC and the Medical Staff petitioners reach agreement on a proposed resolution of the conflict, the proposed resolution shall be submitted to the voting members of the Medical Staff if such action is necessary. If approved by the voting members, the proposal shall be forwarded to the Governing Board for review and consideration. The decision of the Governing Board will be final. In the event that the proposed solution does not require a vote of the Medical Staff, the proposed solution will be forwarded to the Board for a final decision.

(6) If the Board does not approve of the proposed solution (after the vote of the Medical Staff, if necessary, as outlined above), the Board will have th option to request a Joint Conference with representatives of the Board. The MEC (appointed by the President of the Medical Staff) and the petitioners in an effort to seek a final resolution. After such a Joint Conference, the decision of the Board will be final.

(7) In the event that representatives of the MEC and the petitioners cannot agree on a proposed solution, the petition will be forwarded to the Board of review and consideration. The decision of the Board will be final.

11.5 CONTINUOUS QUALITY AND PERFORMANCE IMPROVEMENT COMMITTEE

The Continuous Quality and Performance Improvement Committee shall mean the Medical Staff membership who participate with Hospital leaders and staff in overseeing functions of the Hospital.

ARTICLE XII - MEETINGS

12.1 ANNUAL STAFF MEETING

12.1(a) Meeting Time

The annual Medical Staff meeting shall be held during a month determined by the President of the Medical Staff. The Medical Staff will be given at least two weeks notice of event.

12.1(b) Order of Business & Agenda

The order of business at an annual meeting shall be determined by the President. The agenda shall include:

(1) Reading and accepting the minutes of the last regular and of all special meetings held since the last regular meeting;

(2) Administrative reports from the CEO or his/her designee and the President;

(3) The election of officers and other officials of the Medical Staff when required by these bylaws;

(4) Recommendations for maintenance and improvement of patient care; and

(5) Other old or new business.

12.2 SPECIAL STAFF MEETINGS

12.2(a) Special Meetings

Special meetings of the Medical Staff or any committee may be called at any time by the President and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting unless stated in the meeting notice.

12.3 NOTICE OF MEETINGS

The MEC may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall be required. If a special meeting is called or if the date, hour and place of a regular Medical Staff meeting has not otherwise been announced, the Secretary of the MEC shall give written or e-mail notice stating the place, day and hour of the meeting, delivered either personally or by mail, to each person entitled to be present there at not less than five (5) days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

12.4 QUORUM

12.4(a) General Staff Meeting

The members of the Active Staff who are present at any staff meeting shall constitute a quorum for the transaction of all business at the meeting. Written, signed proxies will not be permitted in any voting at any meeting.

12.4(b) Committee Meetings

The members of a committee who are present, but not less than two (2) members, shall constitute a quorum at any meeting of such committee; except that the MEC shall require fifty (50%) percent of members to constitute a quorum.

12.5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting, either in person or virtually, at which a quorum is present shall be the action of the group. Action may be taken without a meeting of the committee, if a unanimous consent in writing setting forth the action to be taken is signed by each member entitled to vote.

12.6 MINUTES

Minutes of all meetings shall be prepared by the Secretary of the meeting or his/her designee and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees and forwarded to the MEC. A permanent file of the minutes of each meeting shall be maintained.

Complete and detailed minutes must be recorded and maintained.

12.7 ATTENDANCE

12.7(a) Regular Attendance

Members of the Medical Staff are encouraged to attend the regular and special meetings of the Medical Staff as well as the meetings of committees of which they are members.

12.7(b) Special Appearance; Cooperation with Medical Executive Committee

Any committee of the Medical Staff may request the appearance of a Medical Staff member at a committee meeting when the committee is questioning the Practitioner's clinical course of treatment. Such special appearance requirement shall not be considered an adverse action and shall not constitute a hearing under these bylaws. Whenever apparent suspected deviation from standard clinical practice is involved, seven (7) days advance notice of the time and place of the meeting shall be given to the Practitioner. When such special notice is given, it shall include a statement of the issue involved and that the Practitioner's appearance is mandatory. Failure of a Practitioner to appear at any meeting with respect to which he/she was given such special notice shall and/or failure to comply with any reasonable directive of the MEC, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the Practitioner's clinical privileges as the MEC may direct. Such suspensions shall remain in effect until the matter is resolved by the MEC or the Board, or through corrective action, if necessary.

ARTICLE XIII - GENERAL PROVISIONS

13.1 STAFF RULES & REGULATIONS & POLICIES

Subject to approval by the Board, the MEC shall adopt rules and regulations and policies necessary to implement more specifically the general principles found within these bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each staff member or affiliate in the Hospital. The rules and regulations shall be considered a part of these bylaws, except that they may be amended or repealed at any regular meeting at which a quorum present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board. The rules and regulations shall be reviewed periodically, as needed, and shall be revised as necessary to reflect changes in regulatory requirements, corporate and Hospital policies, and current practices with respect to Medical Staff organization and functions.

13.1(a) Notice of Proposed Adoption or Amendment

Where the voting members of the Medical Staff propose to adopt a rule, regulation or policy, or an amendment thereto, they must first communicate the proposal to the MEC at any regular or special meeting of the Medical Staff, which may take place in person or virtually, provided 30 days notice of the proposed amendments are given in writing to all voting staff members prior to said meeting.

Any member of the Active Medical Staff may propose an amendment to these Bylaws by submitting such amendment, in writing, to the President or his/her designee. A proposed amendment shall be referred to the MEC, which shall report on it at the next regular meeting of the Medical Staff or at a special meeting called for such purpose.

To be adopted, an amendment shall require approval by two-thirds of the Active Medical Staff present and voting at the meeting. Amendments so made shall be effective when approved by the Governing Board or any other entity (including, but not limited to, the MEC), but may only be amended in accordance with this Article. Amendments to the Medical Staff Rules and Regulations and Policies may be proposed upon approval of a majority of the voting members of the MEC.

Where the MEC proposes to adopt a rule or regulation, or an amendment thereto, it must first communicate the proposal to the Medical Staff. The MEC is not, however, required to communicate adoption of a policy or an amendment thereto prior to adoption. In such circumstances, the MEC must promptly thereafter communicate such action to the Medical Staff.

Any adoption or amendment to these bylaws or rules and regulations must be forwarded to the Board for consideration. Amendments are effective when approved by the Governing Board.

13.1(b) Provisional Adoption by MEC

In cases of a documented need for urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt, and the Board may provisionally approve, an urgent amendment without prior notification of the Medical Staff.

In such cases, the Medical Staff shall be immediately notified by the MEC. The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MEC, the provisional amendment shall stand. If there is conflict over the provisional amendment, the process described in Section 14.1(c) of this Article shall be implemented.

13.1(c) Management of Medical Staff/MEC Conflicts Related to Rule, Regulation or Policy Amendments

When conflict arises 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, this process shall serve as a means by which these groups can recognize and manage such conflict early and with minimal impact on quality of care and patient safety. Upon notification to the Board Chair of the existence of a conflict, an ad hoc committee selected by the Board Chair shall meet as needed with leaders of the Medical Staff and MEC as early as possible to work with the parties to manage and, when possible, resolve the conflict.

Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Board on a rule, regulation, or policy adopted by the Medical Staff or the MEC or to limit the Board's final authority as to such issues.

13.1(d) Final Authority of the Board

The Board shall have final authority regarding the adoption of any rule, regulation or policy or amendment thereto and no such rule, regulation or policy or amendment thereto, shall be effective until approved by the Board.

13.2 PROFESSIONAL LIABILITY INSURANCE

Each Practitioner or Advanced Practice Professional granted clinical privileges in the Hospital shall maintain in force professional liability insurance in an amount not less than the current minimum state statutory requirement for such insurance or any future revisions thereto, or, should the state have no minimum statutory requirement, in an amount not less than $1,000,000.00 in indemnity limits per occurrence and $3,000,000.00 in indemnity in the aggregate. Policies of insurance in which defense costs reduce the available indemnity limits ("wasting policies") do not meet the requirements of this provision.

The insurance coverage contemplated by this paragraph shall be with a carrier reasonably acceptable to the hospital, and shall be on an occurrence basis or, if on a claims made basis, the Practitioner shall agree to obtain tail coverage covering his/her practice at the hospital. Each Practitioner shall also provide annually to the MEC and CEO the details of such coverage, including evidence of compliance with all provisions of this paragraph. He/She shall also be responsible for advising the MEC and the CEO of any change in such professional liability coverage.

Any Practitioner or Advanced Practice Professional who fails to obtain qualifying insurance coverage pursuant to these bylaws shall be excluded from the medical staff if qualifying coverage is not obtained within fourteen (14) days of the plan expiration or the date that the Practitioner or Advanced Practice Professional knew or should have known that coverage was not adequate. Any Practitioner or Advanced Practice Professional who is excluded from the medical staff in accordance with this provision shall not be eligible for Fair Hearing Procedures.

13.3 CONSTRUCTION OF TERMS & HEADINGS

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

13.4 CONFIDENTIALITY & IMMUNITY STIPULATIONS & RELEASES

13.4(a) Reports to be Confidential

Information with respect to any Practitioner, including applicants, staff members or APPs, submitted, collected or prepared by any representative of the Hospital including its Board or Medical Staff, for purposes related to the achievement of quality care or contribution to clinical research shall, to the fullest extent permitted by the law, be confidential and shall not be disseminated beyond those who need to know nor used in any way except as provided herein. Such confidentiality also shall apply to information of like kind provided by third parties.

13.4(b) Release from Liability

No representative of the Hospital, including its Board, CEO, administrative employees, Medical Staff or third party shall be liable to a Practitioner for damages or other relief by reason of providing information, including otherwise privileged and confidential information, to a representative of the Hospital including its Board, CEO or his/her designee, or Medical Staff or to any other health care facility or organization, concerning a Practitioner who is or has been an applicant to or member of the staff, or who has exercised clinical privileges or provided specific services for the Hospital, provided such disclosure or representation is in good faith and without malice.

13.4(c) Action in Good Faith

The representatives of the Hospital, including its Board, CEO, administrative employees and Medical Staff shall not be liable to a Practitioner for damages or other relief for any action taken or statement of recommendation made within the scope of such representative's duties, if such representative acts in good faith and without malice after a reasonable effort to ascertain the facts and in a reasonable belief that the action, statement or recommendation is warranted by such facts. Truth shall be a defense in all circumstances.

ARTICLE XIV - ADOPTION & AMENDMENT OF BYLAWS

14.1 DEVELOPMENT

The Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board the Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the Hospital, the Board, and the community.

14.2 ADOPTION, AMENDMENT & REVIEWS

The bylaws shall be reviewed and revised periodically and as needed, but at least every three years.[1] When necessary, the bylaws and Rules and Regulations will be revised to reflect changes in regulatory requirements, corporate and Hospital policies, and current practices with respect to Medical Staff organization and functions.

14.2(a) Medical Staff

The Medical Staff Bylaws may be adopted, amended or repealed by the affirmative vote of a two-thirds (2/3) of the Medical Staff members eligible to vote, who are present and voting at a meeting at which a quorum is present, provided at least five (5) days written or electronic notice, accompanied by the proposed bylaws and/or alternatives, has been given of the intention to take such action. This action requires the approval of the Board.

14.2(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.

14.3 AMENDMENTS

These Bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff, which may take place in person or virtually, provided 30 days notice of any proposed amendments are given in writing to all voting staff members prior to said meeting. Any member of the active Medical Staff may propose an amendment to these Bylaws by submitting such amendment, in writing, to the President of his/her designee. A proposed amendment shall be referred to the MEC, which shall report on it at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. To be adopted, an amendment shall require approval by two-thirds of the Active Medical Staff present and voting at the meeting. Amendments so made shall be effective when approved by the Governing Board. These Bylaws may not be amended unilaterally by action of the Medical Staff, the Governing Board or any other entity (including, but not limited to, the MEC), but may only be amended in accordance with this Article.

Medical Staff Rules and Regulations and Policies are attached, hereto, as Article XIII. Amendments to the Medical Staff Rules and Regulations and Policies may be proposed upon approval of a majority of the voting

[1] unless state law requires differently

members of the MEC, and forwarded to the Board for consideration. Amendments are effective when approved by the Governing Board.

14.4 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

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

14.3(a) Appending to these bylaws the approved amendment, which shall be dated and signed by the President, the CEO, the Chairperson of the Board of Managers and approved by corporate legal counsel as to form; or

14.3(b) 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 President, the CEO and the Chairperson of the Governing Board 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.

MEDICAL STAFF BYLAWS
ADOPTED & APPROVED:

MEDICAL STAFF:

By: _____ _____
President Date

GOVERNING BOARD:

By: _____ _____
Chairperson Date

COMMUNITY REHABILITATION HOSPITAL NORTH:

By: _____ _____
Chief Executive Officer Date

APPROVED AS TO FORM:

By: _____ _____
Legal Counsel for Community Health Network Rehabilitation Hospital, LLC Date

APPROVED:

By: _____ _____
Group President Date

APPENDIX "A" – FAIR HEARING PLAN

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

DEFINITIONS

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

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

2. "Corporation" shall mean Community Health Network Rehabilitation Hospital, LLC.

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

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

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

ARTICLE I - INITIATION OF HEARING

1.1 RECOMMENDATION OR ACTIONS

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

(1) Denial of initial staff appointment;

(2) Denial of reappointment;

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

(4) Revocation of staff membership;

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

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

(7) Limitation of the right to admit patients;

(8) Denial of an initial request for particular clinical privileges;

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

(10) Permanent suspension of clinical privileges;

(11) Revocation of clinical privileges;

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

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

1.2 WHEN DEEMED ADVERSE

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

(1) Recommended by the MEC; or

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

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

1.3 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

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

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

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

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

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

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

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

1.4 REQUEST FOR HEARING

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

1.5 WAIVER BY FAILURE TO REQUEST A HEARING

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

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

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

ARTICLE II - HEARING PREREQUISITES

2.1 NOTICE OF TIME & PLACE FOR HEARING

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

2.2 STATEMENT OF ISSUES & EVENTS

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

2.3 PRACTITIONER'S RESPONSE

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

2.4 EXAMINATION OF DOCUMENTS

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

2.5 APPOINTMENT OF HEARING COMMITTEE

2.5(a) By Medical Staff

A hearing occasioned by an adverse MEC recommendation pursuant to Article I, Section 1.2(1) shall be conducted by a Hearing Committee appointed by the President and composed of three (3) members of the Medical Staff. None of the Hearing Committee members shall be partners, associates, relatives or in direct economic competition with the affected individual. Should the President find it impossible to appoint a committee meeting the above requirements or otherwise find good cause to utilize Practitioners outside the staff, he/she may, upon approval by the CEO, appoint an independent panel of three (3) Practitioners meeting all requirements of this section with the exception of Medical Staff membership.

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

determination. The President shall advise the affected individual accordingly. One (1) of the members so appointed shall be designated as Chairperson.

2.5(b) By Board

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

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

2.5(c) Service on Hearing Committee

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

ARTICLE III - HEARING PROCEDURE

3.1 PERSONAL PRESENCE

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

3.2 PRESIDING OFFICER

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

3.3 REPRESENTATION

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

3.4 RIGHTS OF THE PARTIES

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

(1) Call and examine witnesses;

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

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

(4) Impeach any witness;

(5) Rebut any evidence;

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

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

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

3.5 PROCEDURE & EVIDENCE

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence although these rules may be considered in determining the weight of the evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of admissibility of such evidence in a court of law. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall

become part of the hearing record. The Presiding Officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him/her and entitled to notarize documents in the state where the hearing is held.

3.6 OFFICIAL NOTICE

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

3.7 BURDEN OF PROOF

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

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

3.8 RECORD OF HEARING

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

3.9 POSTPONEMENT

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

3.10 PRESENCE OF HEARING COMMITTEE MEMBERS & VOTING

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

3.11 RECESSES & ADJOURNMENT

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

3.12 HEARING COMMITTEE PARTICIPATION

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

ARTICLE IV - HEARING COMMITTEE REPORT & FURTHER ACTION

4.1 HEARING COMMITTEE REPORT

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

4.2 ACTION ON HEARING COMMITTEE REPORT

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

4.3 NOTICE & EFFECT OF RESULT

4.3(a) Notice

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

4.3(b) Effect of Favorable Result

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

(2) Adopted by the Medical Executive Committee: If the MEC's result is favorable to the Practitioner, the CEO shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereon by adopting or rejecting the MEC's result in whole or in part, or by referring the matter back to the MEC for further consideration. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, and consultation with the Corporation as necessary, the Board shall take final action. The CEO shall promptly send the Practitioner special notice informing him/her of each action taken pursuant to this Article IV, Section 4.3(b)(2). Favorable action shall become the final decision of the Board, and the matter shall be considered finally closed.

4.3(c) Effect of Adverse Result

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

ARTICLE V - INITIAL & PREREQUISITES OF APPELLATE REVIEW

5.1 REQUEST FOR APPELLATE REVIEW

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

5.2 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW

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

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

5.3 NOTICE OF TIME & PLACE FOR APPELLATE REVIEW

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

5.4 APPELLATE REVIEW BODY

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

ARTICLE VI - APPELLATE REVIEW PROCEDURE

6.1 NATURE OF PROCEEDINGS

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

6.2 WRITTEN STATEMENTS

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

6.3 PRESIDING OFFICER

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

6.4 ORAL STATEMENT

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

6.5 CONSIDERATION OF NEW OR ADDITIONAL MATTERS

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report, and not otherwise reflected in the record shall not be introduced at the Appellate Review, except by leave of the Appellate Review Body. The Appellate Review Body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted, following establishment of good cause by the party requesting the consideration of such matter or evidence as to why it was not presented earlier. If such additional evidence is considered, it shall be subject to cross examination and rebuttal.

6.6 PRESENCE OF MEMBERS & VOTING

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

6.7 RECESSES & ADJOURNMENT

The Appellate Review Body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of consultation. Upon the conclusion of oral statements, if allowed, the Appellate Review shall be closed. The Appellate Review Body shall thereupon,

at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the Appellate Review shall be declared finally adjourned.

6.8 ACTIONS TAKEN

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

6.9 CONCLUSION

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

ARTICLE VII - FINAL DECISION OF THE BOARD

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

ARTICLE VIII - GENERAL PROVISIONS

8.1 HEARING OFFICER APPOINTED & DUTIES

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

8.2 ATTORNEYS

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

8.3 NUMBER OF HEARINGS & REVIEWS

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

8.4 RELEASE

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

8.5 WAIVER

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

ARTICLE IX – AMENDMENT OF FAIR HEARING PLAN

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

FAIR HEARING PLAN
ADOPTED & APPROVED:

MEDICAL STAFF:

By: _____ _____
President Date

GOVERNING BOARD:

By: _____ _____
Chairperson Date

COMMUNITY REHABILITATION HOSPITAL NORTH:

By: _____ _____
Chief Executive Officer Date

APPROVED AS TO FORM:

By: _____ _____
Legal Counsel for Community Health Network Rehabilitation Hospital, LLC Date

APPROVED:

By: _____ _____
Group President Date

APPENDIX "B" – RULES & REGULATIONS

These Rules & Regulations are adopted in connection with the Medical Staff Bylaws and made a part thereof. The definitions and terminologies of the bylaws also apply to the Rules & Regulations and proceedings hereunder.

ARTICLE I - ADMISSION & DISCHARGE OF PATIENTS

1.1 ADMISSION OF PATIENTS

The admission policy is as follows:

1.1(a) All patients admitted to the Hospital shall have a provisional or admission diagnosis. A provisional diagnosis for emergency admissions shall be provided as promptly as possible.

1.1(b) All patients admitted to the Hospital shall have an Individualized Written Plan of Care (IPOC).[2] 1.1(c) A patient may be admitted to the Hospital only by an attending rehabilitation physician member of the Medical Staff. The privilege to admit shall be delineated, and is not automatic with Medical Staff membership. A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained the time of admission. The admitting office will notify the attending practitioner whenever such consent has not been obtained.

1.1(d) Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure protection of other patients or to assure protection of the patient from self harm.

1.1(e) The management and coordination of each patient's care, treatment and services shall be the responsibility of a physician with appropriate privileges. Each Medical Staff member shall be responsible for the medical care and treatment of each of his/her hospitalized patients, for the prompt completeness and accuracy of the medical record, for necessary special instructions, for transmitting reports of the condition of the patient to any referring Practitioner and to relatives of the patient where appropriate. The patient shall be provided with pertinent information regarding outcomes of diagnostic tests, medical treatment and surgical intervention. Whenever a physician's responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical records. Failure of an attending physician to meet these requirements may result in loss of clinical privileges. When a practitioner is out of town or not available, the on-call schedule shall indicate in writing the name of the practitioner who will be assuming responsibility for the care of the patient during their absence.

1.1(f) Each member of the Medical Staff shall designate a member of the Medical Staff who may be called to care for his/her patients in an emergency at those times the Attending Physician is not readily available. In cases of inability to contact the Attending Physician, the following should be contacted, in order of priority listed below:

(1) An alternate physician (preferably a partner, associate or designee of the Attending Physician);

(2) The President, who may assume care for the patient or designate any appropriately trained member of the staff; or

(3) In the absence of the above, any appropriately trained member of the Medical Staff requested by the CEO to provide care for the patient.

1.1(g) The physician certification must be completed, signed, dated and documented in the medical record prior to discharge unless otherwise permitted by law. This requires authentication of the order for inpatient admission prior to discharge.

[2] 42 CFR § 412.622(a)(4)(ii) and The Medicare Benefit Policy Manual, Chapter 1 Under Part A, Section 110.1.3

1.1(h) The practice of division of fees under any guise whatsoever is forbidden.

1.1(i) A patient to be admitted on a transfer basis who does not have a private physician may request any physician on the Medical Staff to attend them. Where no such request is made, or if the requested physician not on call does not assume care of the patient, then a member of the active Physical Medicine & Rehabilitation physician on staff will be assigned to the patient. If the "on call" practitioner for good cause cannot assume care of the patient, then the practitioner who is next "on call" will be assigned to the patient. The Medical Director shall provide a schedule of "on call" assignments.

1.1(j) The Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof.

1.1(k) Patients will be admitted on the basis of the following order of priorities:

(1) In the event that sufficient beds are unavailable when approved patients are ready for admission, the Clinical Liaisons will confer with the Area Director of Business Development and the CEO to determine the priority of admission for these patients; or

(2) Factors to be considered in determining priority include:

(i) Length of time the patient has been awaiting a bed;

(ii) Urgency of need for rehabilitative care, for example, patients whose care may be compromised if they remain in their current setting;

(iii) Special needs of the patient and our ability to accommodate those needs with the available beds; and

(iv) Medical Stability.

1.2 ADMITTING POLICY

Priorities for admission are as follows:

1.2(a) Emergency Admissions

Within twenty-four (24) hours following all admissions, the responsible provider shall have a history and physical or assessment dictated documenting the need for the admission. Failure to furnish this documentation or evidence of willful or continued misuse of this category of admission will be brought to the attention of the Medical Executive Committee (MEC) for appropriate action.

1.2(b) Non-operative Nonelective Admissions

This will include medically necessary non-elective admissions involving all services.

1.2(c) Non-Operative Elective Admissions

This includes elective admissions involving non-operative services

1.3 PATIENT TRANSFERS

1.3(a) No patient will be transferred without such transfer being approved by the responsible practitioners (transferring and receiving).

1.3(b) Transferring physician shall retain responsibility for patient until receiving physician in this Hospital accepts patient.

1.3(c) Procedures for the referral and/or transfer of patients exhibiting severe psychiatric symptoms shall be as follows:

(1) As soon as it is recognized that a patient's behavior represents a hazard to their personal security and safety or the security and safety of their surroundings or other persons in the Hospital, they will be transferred to an appropriate facility;

(2) Although the responsibility for the referral and transfer of patients is the attending physician's when an emergency arises and the physician is not immediately available, the order can be issued by the Medical Director or other member of the Medical Staff. The Chief Clinical Officer or Administrator on Call will be contacted and asked to provide assistance;

(3) Notification of the Psychologist will be routine and is the responsibility of the charge nurse. Upon the request of the attending physician or their representative, a Psychologist will provide assistance in a family instruction, selection of facilities and resources and other matters relating to the transfer of the patient; and

(4) If the patient's need for acute rehab care is so urgent as to mitigate against the patient's transfer, the attending physician will immediately notify the CEO or Chief Clinical Officer and apprise them of their recommendations and plans concerning the care of the patient. The ultimate disposition of the patient will then be determined by the attending physician in consultation with representatives of the administration, nursing service and other members of the Medical Staff as indicated or requested.

1.4 SUICIDAL PATIENTS

For the protection of patients, the medical and nursing staff, and the Hospital, the care of the potentially suicidal patient shall be as follows:

1.4(a) A patient suspected to be suicidal in intent shall be admitted to an appropriate room consistent with the patient's medical needs and Hospital policy. If these accommodations are not available, the patient shall be transferred, if possible, to another institution where suitable facilities are available. When transfer is not possible, the patient may be admitted to a general area of the Hospital as a temporary measure. Appropriate restraints may be used as permitted by these Rules & Regulations or Hospital policy. The patient will be afforded psychiatric consultation; and

1.4(b) The Hospital social worker should be consulted for assistance.

1.5 USE OF RESTRAINTS

The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever their patients might be a source of danger.

1.5(a) Use of Restraints – The safety of the patients admitted is of utmost concern; therefore, all patients admitted to Hospital will be cared for in a safe environment. Generally speaking, restraints are to be utilized to enhance patient safety. Details about the use of restraints are found in the Provision of Care Manual, Restraints policy.

1.6 DISCHARGE OF PATIENTS

The discharge policy is as follows:

1.6(a) Patients shall be discharged only on a written order of the Attending Physician. Should a patient leave the Hospital against the advice of the Attending Physician or without proper discharge, a notation of the incident shall be made in the patient's medical record by the Attending Physician. The discharge process and corresponding documentation shall provide for continuing care based on the patient's assessed needs at the time of discharge.

1.6(b) If any questions as to the validity of admission to or discharge from the facility should arise, the subject shall be referred to the Physician Advisor for assistance.

1.6(c) The Attending Physician is required to document the need for continued hospitalization prior to expiration of the designated length of stay. This documentation must contain:

(1) Adequate documentation stating the reason for continued hospitalization. A simple reconfirmation of the diagnosis will not be considered adequate;

(2) Estimate of additional length of stay the patient will require; and

(3) Plans for discharge and post-hospital care.

Upon request of the Utilization Management Committee or other committee responsible for case management, the Attending Physician must provide written justification of the necessity for continued hospitalization of any patient hospitalized longer than specified by the committee, including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within a reasonable period of time. Failure to comply with this policy will be brought to the attention of the MEC for action.

1.6(d) The Attending Physician shall keep the patient and the patient's family informed concerning the patient's condition throughout the patient's term of treatment. The Attending Physician and Hospital staff shall ensure that the patient (or appropriate family member or legally designated representative) is provided with information that includes, but is not limited to, the following:

(1) Conditions that may result in the patient's transfer to another facility or level of care;

(2) Alternatives to transfer, if any;

(3) The clinical basis for the discharge;

(4) The anticipated need for continued care following discharge;

(5) When indicated, educational information regarding how to obtain further care, treatment, and services to meet the patient's needs, which are arranged by or assisted by the hospital; and

(6) Written discharge instructions in a form and manner that the patient or family member can understand.

1.6(e) Patients may not be released from the Hospital for the purpose of receiving professional care, consultation or treatment in a doctor's office or another health care facility, or for leave of absence for any reason, unless they sign a Release of Responsibility.

1.6(f) A discharge summary is required for all patients hospitalized more than forty-eight (48) hours or with inpatient status. Discharge summaries are to include the following:

(1) Final Diagnosis;
(2) Reason for hospitalization;
(3) Significant findings;
(4) Procedures performed;
(5) Care, treatment and services provided;
(6) Patient's condition and disposition at discharge; and
(7) Information provided to the patient, patient's family, or legal guardian, including for the provision of follow-up care and a list of any post-discharge medications.

1.7 UNANTICIPATED OUTCOMES

In the event of an unanticipated outcome or adverse event, the patients' treating and/or consulting physician shall participate in discussion of the outcome or event with the patient, family and/or legal representative to the extent appropriate under the Hospital's Policy on Disclosure of Treatment Outcomes.

ARTICLE II - MEDICAL RECORDS

2.1 PREPARATION/COMPLETION OF MEDICAL RECORDS

The Attending Physician shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. The record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, special reports, such as consultations, clinical laboratory, radiology services, other diagnostic and therapeutic orders and results thereof, provisional diagnosis, medical treatments, pathological findings, progress notes, final diagnosis, condition on discharge, discharge summary or note, and clinical résumé, when performed. The record shall also contain a report of any emergency care provided to the patient; evidence of known advance directives; documentation of consent; and a record of any donation of organs or tissue or receipt of transplant or implants. The record shall also contain a written plan of care, treatment and services appropriate to the patient's needs, identifying the patient's needs, goals, timeframes, settings, and services required to meet the patient's needs. Such plan of care shall be discussed with the patient and shall be revised as necessary, and where appropriate, consider strategies to limit the use of restraints and/or seclusion of the patient.

The Medical Record shall include Computerized Physician Order Entries as required by these Rules & Regulations in order to be considered complete.

2.2 ADMISSION HISTORY

Each patient admitted for inpatient care shall have either a complete admission history and physical examination or an assessment as required by the Medical Staff Bylaws.

2.3 PROGRESS NOTES

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. Progress notes shall be written or dictated at least daily on all patients except on the day of admission. The written admission note shall serve as the progress note for the day of admission, unless the patient's condition warrants further progress notes on that date**.**

2.4 CONSULTATIONS

It will be the responsibility of the Attending Physician to obtain consultation in those circumstances outlined in the mandatory consultation policy of this Hospital. Consultations shall be obtained through written order of the Attending Physician. The consultation report shall include evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. The report shall be made a part of the patient's record.

2.5 CLINICAL ENTRIES/AUTHENTICATION

All clinical entries in the patient's medical record, including written and verbal orders, shall be accurately and promptly dated, timed, authenticated and legible. Authentication shall be defined as the establishment of authorship by written signature, identifiable initials or computer key. The use of a rubber stamp signature is not acceptable.

2.6 ABBREVIATIONS/SYMBOLS

MEC will approve a list of abbreviations and symbols for the "do not use" list. Abbreviations and symbols listed on the "do not use" list may be utilized in medical records. This list shall be filed with the Health Information Management Department. Abbreviations and symbols may not be used in the final diagnostic statement or in documentation of an operative procedure.

2.7 FINAL DIAGNOSIS

The final diagnosis pending the results of lab, pathology and other diagnostic procedures shall be recorded in full without the use of symbols or abbreviations. It shall also be dated and signed by the responsible Practitioner at the time of discharge of all patients.

2.8 REMOVAL OF MEDICAL RECORDS

Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records, including imaging films, are the property of the Hospital and shall not otherwise be removed from the premises. In cases of patient readmissions, all previous records shall be available for the use of the Attending Physician. This shall apply whether the patient is attended by the same Practitioner or by another. Unauthorized removal of records from the Hospital is grounds for suspension of the Practitioner for a period to be determined by the MEC.

2.9 ACCESS TO MEDICAL RECORDS

Access to all patient medical records shall be afforded to members of the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the MEC before records can be studied. Subject to the discretion of the President, former members of the Medical Staff shall be permitted access to information from the medical records of their patients, covering all periods during which they attended such patients in the Hospital.

Certain types of information, including, but not limited to, psychiatric medical records, alcohol and drug abuse records and HIV records are protected by statute, and require a signed release from the patient or a court order before being released to any person.

Information should not be released to a patient's family member unless a signed consent has been obtained from the patient, guardian, or legally authorized individual.

2.10 PERMANENTLY FILED MEDICAL RECORDS

A medical record shall not be permanently filed until it is completed by the responsible Practitioner(s) or is ordered filed by the MEC, the President or CEO with an explanation of why it was not completed by the responsible Practitioner(s).

2.11 STANDING ORDERS

In order to ensure continued appropriateness, Practitioner-specific standing orders shall be reviewed semi-annually by the physician and the Utilization Management Committee. Standing orders shall be dated and signed by the Practitioner and reproduced in detail on the order sheet of the patient's record. Standing orders shall not replace or void those orders written for a specific patient.

2.12 COMPLETION OF MEDICAL RECORDS

The patient's medical record shall be complete at the time of discharge, including progress notes and final diagnosis. The written or dictated discharge summary shall be completed within thirty (30) days of discharge, provided, however, inpatient admission orders must be completed in accordance with the Inpatient Order for Patient Status Policy. When final laboratory or other essential reports are not received at the time of discharge, a notation shall be written or dictated that this information is pending.

2.13 DELINQUENT MEDICAL RECORDS

Patient medical records are required to be completed within thirty (30) days of discharge. The Health Information Management Department will provide each physician with a list of his/her incomplete medical records every seven (7) days. At the twenty-first (21st) day for any incomplete medical records, the letter will include a warning that the record(s) will be delinquent at thirty (30) days and the physician's privileges will be suspended if any records become delinquent.

2.13(a) Suspension. A chart which is not completed within thirty (30) days of discharge will trigger suspension of the responsible physician's privileges. When a staff member is notified of suspension, the staff member may not provide any hands-on patient care. New admissions or the scheduling of procedures are not permitted. Consultations are not permitted. The suspended physician may not provide coverage for partners or other physicians, nor admit under a partner's or other Attending Physician's name. Any exceptions must be approved by the President and the CEO.

2.13(b) The suspended staff member is obligated to provide to the Hospital CEO and the President the name of another physician who will take over the care of his/her hospitalized patients, take his/her call, consultations, and any other services that physician provides.

2.13(c) Relevant Hospital personnel shall be notified of a suspension to enable the enforcement of the suspension.

2.13(d) Any physician who remains on suspension for seven (7) calendar days or longer will be referred to the MEC for further action.

A medical record shall not be permanently filed until it is completed by the responsible Practitioner(s) or is ordered filed by the CEO, or the chairperson of the Quality Management Committee, or equivalent Medical Staff committee.

2.14 TREATMENT & CARE WRITTEN ORDERS

Orders for treatment and care of patients may be written by Advanced Practice Professionals in accordance with state law.

Preoperative orders must be cosigned prior to being followed unless the orders are verbal telephone orders given by the physician as prescribed in Article III, Section 3.2 of these Rules & Regulations.

2.15 ALTERATIONS/CORRECTION OF MEDICAL RECORD ENTRIES

Only the original author of a medical record entry is authorized to correct or amend an entry. Any correction must be dated and authenticated by the person making the correction. Medical record entries may not be erased or otherwise obliterated, including the use of "white-out".

To correct or amend an entry, the author should cross out the original entry with a single line, ensuring that it is still readable, enter the correct information, sign with legal signature and title, and enter the date and time the correction was made.

Any alteration in the medical record made after the record has been completed is considered to be an addendum and should be dated, signed and identified as such.

2.16 COMPUTERIZED PHYSICIAN ORDER ENTRY

CPOEs shall be utilized by providers to the extent available and operational.

ARTICLE III - GENERAL CONDUCT OF CARE

3.1 CONSENT FORM

A consent to treatment form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The patient business office should notify the Attending Physician whenever such consent has not been obtained. When so notified it shall, except in emergency situations, be the Practitioner's obligation to obtain proper consent before the patient is treated in the Hospital.

3.2 WRITTEN/VERBAL/TELEPHONE TREATMENT ORDERS

A verbal or telephone order shall be considered to be in writing if dictated to an R.N. and signed by the R.N. and countersigned by the physician giving the order. Registered physical therapists, lab technicians, radiology technologists, clinical dieticians, respiratory therapy technicians, and pharmacists may accept verbal orders relating to their area of practice. All verbal and telephone orders shall be signed by the qualified person to whom the order is dictated. The recipient's name, the name of the Practitioner, and the date and time of the order shall be noted. The recipient shall indicate that he/she has written or otherwise recorded the order and shall read the verbal order back to the physician and indicate that the individual has confirmed the order. The physician who gave the verbal order or another Practitioner (who is credentialed and granted privileges to write orders) who is also responsible for the care of the patient shall authenticate, time and date any order, including but not limited to medication orders, as soon as possible, such as during the next patient visit, and in no case longer than forty-eight (48) hours from dictating the verbal order.[3] Failure to do so shall be brought to the attention of the MEC for appropriate action. Orders for tests require documentation of a diagnosis for which the test is necessary.

3.3 ILLEGIBLE TREATMENT ORDERS

The Practitioner’s orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

3.4 ADMINISTRATION OF DRUGS/MEDICATIONS

All drugs and medications administered to patients shall be those listed in the Formulary of the American Society of Hospital Pharmacists.

3.5 ORDERING/DISPENSING OF DRUGS

The physician must order drugs by name, dose, route and frequency of administration. Drugs shall be dispensed from and reviewed by the Hospital pharmacist, or as circumstances demand (i.e., exigent patient need, or unavailability of the pharmacist) another qualified health care professional, subject to retrospective review by the Hospital pharmacist to determine: the appropriateness of the medication, dose, frequency, and route of administration; therapeutic duplication; real or potential allergies or sensitivities; real or potential interactions between the prescribed medication and other medications, food, and laboratory values; other contraindications; and variation from Hospital dispensing criteria. When the patient brings medication to the Hospital with him/her, those medications which are clearly identified may be administered by the nursing staff only if ordered by the physician and verified and identified by the Pharmacist on duty. Upon discharge all medications shall be returned to the patient. The Director of Pharmacy shall be consulted for any deviations from this rule and his/her decision shall be binding. Medications ordered to be “held” will be discontinued after twenty-four (24) hours in the absence of a “resume” order. The physician must document in the medical record a diagnosis, condition, and indication-for-use for each medication ordered.

[3] To be dictated by State Law requirements

3.6 QUESTIONING OF CARE

If a nurse or other provider has any reason to question the care provided to any patient, or believes that consultation is needed and has not been obtained, he/she shall call this to the attention of his/her supervisor, who in turn may refer the matter to the Chief Nursing Officer. The Chief Nursing Officer shall contact the Attending Physician to attempt to alleviate this question. The Chief Nursing Officer may then bring this matter to the attention of the President. If the circumstances are such as to justify such action, the President may request a consultation.

3.7 PATIENT CARE ROUNDS

Hospitalized patients shall be seen by the attending physician or his/her designated alternate at least three (3) times every seven (7) days more frequently if their status warrants and provide an updated note on the patient's condition and progress.

3.8 ATTENDING PHYSICIAN UNAVAILABILITY

Should the Attending Physician be unavailable, his/her designee will assume responsibility for patient care.

3.9 PATIENT RESTRAINT ORDERS

All Medical Staff members shall abide by federal law, Joint Commission standards, and all Hospital policies pertaining to restraints and seclusion.

3.10 PRACTITIONERS ORDERING TREATMENT

Licensure and Medicare/Medicaid eligibility will be verified for all Practitioners ordering treatment (i.e. home health, cardiac rehabilitation, physical therapy, chemotherapy), regardless of the Practitioner's Medical Staff status or lack thereof. Orders for services may only be made by Practitioners who are (1) responsible for the care of the patient; (2) licensed in, or holds a license recognized in, the jurisdiction where he/she provides care to the patient; (3) acting within his/her scope of practice under State law; and (4) authorized by the Medical Staff to order the applicable services under a written Hospital policy that is approved by the Board. This includes both Practitioners who are on the Hospital Medical Staff, as well as other Practitioners who are not on the Hospital Medical Staff, but who satisfy the Hospital's policies for ordering applicable services.

3.11 TREATMENT OF FAMILY MEMBERS OR SELF-TREATMENT

Practitioners may not treat themselves or their immediate family members. This includes self-prescribing or prescribing to immediate family members any controlled substances.

ARTICLE IV - ADOPTION & AMENDMENT OF RULES & REGULATIONS

4.1 DEVELOPMENT

The MEC shall have the initial responsibility to bring before the Board formulated, adopted and recommended Medical Staff Rules & Regulations and amendments thereto which shall be effective when approved by the Board. The MEC shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest or providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the CEO, the Board and the community.

4.2 ADOPTION, AMENDMENT & REVIEWS

These rules and regulations shall be considered a part of the bylaws, except that they may be amended or replaced at any regular MEC meeting at which a quorum present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. These actions require the approval of a majority of the Board. If the MEC fails to act within a reasonable time after notice from the Board to such effect, the Board may initiate revisions to the Medical Staff Rules & Regulations, taking into account the recommendations of Medical Staff members. The Rules & Regulations shall be reviewed and revised as needed, but at least every two (2) years.

4.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

Amendments to these Rules & Regulations as set forth herein shall be documented by either:

4.3(a) Appending to these Rules & Regulations the approved amendment, which shall be dated and signed by the President, the CEO, the Chairperson of the Governing Board and approved as to form by Corporate Legal Counsel; or

4.3(b) Restating these Rules & Regulations, incorporating the approved amendments and all prior approved amendments which have been appended to these Rules & Regulations since their last restatement, which restated Rules & Regulations shall be dated and signed by the President, the CEO, the Chairperson of the Governing Board and approved as to form by Corporate Legal Counsel.

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

4.4 SUSPENSION, SUPPLEMENTATION, OR REPLACEMENT

The Board reserves the right to suspend, override, supplement, or replace all or a portion of the Rules and Regulations in the event of exigent and compelling circumstances affecting the operation of the Hospital, welfare of its employees and staff, or provision of optimal care to patients. However, should the Board so suspend, override, supplement or replace such rules and regulations, it shall consult with the Medical Staff at the next regular staff meeting (or at a special called meeting as provided in the bylaws), and shall thereafter proceed as provided in Section 8.2 for adoption and amendment of Rules & Regulations. If an agreement cannot be reached, the Board shall have the ultimate authority as to adoption and amendment of the Rules & Regulations, but shall exercise such authority unilaterally only when the MEC has failed to fulfill its obligations and it is necessary to ensure compliance with applicable law or regulation, or to protect the well-being of patients, employees or staff.

MEDICAL STAFF RULES & REGULATIONS
ADOPTED & APPROVED:

MEDICAL STAFF:

By: _____ _____
President Date

GOVERNING BOARD:

By: _____ _____
Chairperson Date

COMMUNITY REHABILITATION HOSPITAL NORTH:

By: _____ _____
Chief Executive Officer Date

APPROVED AS TO FORM:

By: _____ _____
Legal Counsel for Community Health Network Rehabilitation Hospital, LLC Date

APPROVED:

By: _____ _____
Group President Date

APPENDIX "C" – POLICY RE: BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY

1.1 PURPOSE & OBJECTIVE

It is the policy of the Hospital for all individuals working in the Hospital to treat others with respect, courtesy, and dignity, and to conduct ourselves in a professional, cooperative manner, and in compliance with the Code of Conduct of LifePoint Hospitals. This policy sets forth the requirement that all physicians and advanced practice professionals who work in the Hospital will act in a professional and respectful manner at all times. Further, this policy defines behavior or behaviors that undermine a culture of safety, and outlines how to report and address it.

The objectives of this policy are to ensure quality patient care by promoting a safe, cooperative, and professional health care environment, and to provide Hospital employees with a work environment based on respect and one that encourages personal and professional growth.

This policy is applicable to all medical staff members and all advanced practice professionals (collectively referred to in this policy as "Practitioners").

Conduct of a criminal nature by a Practitioner, including but not limited to assault, battery, rape, or theft shall be handled through local law enforcement officials in accordance with local and State laws, in addition to application of this policy to address Practitioner's medical staff or advanced practice membership.

Any employee who engages in behavior or behaviors that undermine a culture of safety, including employed Practitioners, may be dealt with in accordance with the Hospital's human resource policies. Practitioners or Hospital employees who observe undermining behavior on the part of a Hospital employee shall follow the reporting mechanisms set forth in the human resource policies.

2.1 BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY

For purposes of this policy, behavior that undermines the culture of safety (herein referred to as "Undermining Behavior") is any behavior that substantially intimidates others; affects morale or staff turnover; disrupts the smooth operation of the Hospital; adversely affects the ability of others to perform their jobs appropriately; poses a threat or potential threat to safe quality patient care; or exposes the Hospital or Medical Staff to potential liability. Behavior that does not substantially impact a culture of safety is behavior that is outside the scope of this policy. Behavior which may rise to the level of Undermining Behavior may include, but is not limited to, behavior such as:

2.1(a) Rude, abusive or intimidating behavior or comments to Hospital personnel, other Practitioners, Hospital visitors, patients or their families, or other behavior that negatively affects the ability of others to do their jobs. Such behavior can include the failure to cooperate, the refusal to return calls, or other passive activities when such substantially impacts the culture of safety.

2.1(b) Attacks, verbal or physical, directed at other Practitioners, Hospital personnel, patients or visitors, that are personal, inappropriate, irrelevant, or beyond the bounds of fair professional conduct.

2.1(c) Impertinent and inappropriate comments (or illustrations) made in patient medical records or other official documents, or inappropriate written or verbal statements to patients and/or members of the community impugning the quality of care in the Hospital, or attacking particular Practitioners, nurses, other Hospital employees, or Hospital policies.

2.1(d) Non-constructive criticism that is addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence.

2.1(e) Refusal to accept, or causing a disturbance of, medical staff assignments or participation in committee affairs.

2.1(f) Interference with Hospital operations, Hospital or Medical Staff committees, or placing quality care at the Hospital in jeopardy.

2.1(g) Knowingly making false accusations or falsifying any patient medical records or Hospital documents.

2.1(h) Verbal or physical maltreatment of another individual, including physical or sexual assault or battery, or retaliation of any kind for making a report under this policy.

2.1(i) Sexual, racial, or other harassment, including words, gestures and actions, verbal or physical, that interferes with a person's ability to perform his or her job.

2.1(j) Behavior that adversely affects or impacts the community's confidence in the Hospital's ability to provide quality patient care.

3.1 REPORTING OF UNDERMINING BEHAVIOR

3.1(a) Hospital employees who observe, or are subjected to, Undermining Behavior by a Practitioner should notify their supervisor about the incident. If the supervisor's behavior is at issue, the employee should notify the Chief Executive Officer (or his or her designee) or the Hospital Human Resources Director. Any Practitioner who observes Undermining Behavior of another Practitioner shall notify the Chief Executive Officer directly. Supervisors who have received a report of Undermining Behavior shall report the same to the Chief Executive Officer.

3.1(b) If a reporting individual is uncomfortable with reporting Undermining Behavior directly, then a report of the incident must be made to the Hospital's Ethics & Compliance Officer or the LifePoint Ethics Line at 1-877-508-LIFE (5433).

4.1 DOCUMENTATION

4.1(a) Documentation of Undermining Behavior is critical since it is ordinarily a pattern of conduct, rather than one (1) incident, which justifies disciplinary action. Practitioners, nurses and other Hospital employees who observe and report Undermining Behavior by a Practitioner must document the behavior or in the alternative, the supervisor/Chief Executive Officer shall document the incident as reported. That documentation shall include:

(1) The date, time, and location of the questionable behavior;

(2) A statement of whether the behavior affected or involved a patient in any way; and if so, the medical record number of the patient;

(3) Known circumstances which precipitated the situation;

(4) A factual description of the questionable behavior limited to factual, objective language;

(5) Known consequences, if any, of the Undermining Behavior as it relates to patient care or Hospital operations;

(6) The names of other witnesses to the incident; and

(7) A record of any action taken to remedy the situation including date, time, place, action, and name(s) of those intervening.

4.1(b) The report shall be submitted to the Chief Executive Officer, who shall provide the report to the President. In performing all functions hereunder, the Chief Executive Officer and President, and their designees, shall be deemed authorized agents of the Medical Executive Committee and shall enjoy all immunity and confidentiality protection afforded under state and federal law.

4.1(c) After a report of Undermining Behavior, the Chief Executive Officer or his or her designee shall insure those making the report are aware of the Hospital's standards of behavior and process for assuring professional and appropriate behavior in the Hospital. Individuals that reported the potentially undermining behavior will be advised of policies preventing retaliation and will be requested to report any perceived acts of retaliation to the CEO or his or her designee. This follow-up discussion with individuals that made a report will occur as soon as practical after each report of Undermining Behavior.

5.1 INVESTIGATION

Once received, a report will be investigated by the Chief Executive Officer and/or the President. The Chief Executive Officer may delegate this investigation to the Hospital's Human Resources Director, Chief Nursing Officer, or other individual who may have applicable expertise or skill. This investigation may include meeting with the individual who reported the behavior and any other witnesses to the incident. If the Chief Executive Officer and President determine after investigation that the report lacks merit, this conclusion shall be documented and no further action is necessary. Those reports considered accurate will be addressed through the procedure set out below. This documentation shall be placed in the Practitioner's confidential peer review file. If at any time it appears to the President, the Chief Executive Officer, or any committee charged with implementation of this policy that a physician's behavior may result from impairment, the procedure set forth in the Practitioner Wellness Policy shall be followed.

6.1 MEETING WITH THE PRACTITIONER

6.1(a) A first confirmed incident requires a discussion with the offending Practitioner. The President and Chief Executive Officer **shall** initiate a meeting with the Practitioner and emphasize that such behavior is inappropriate and violates Hospital policy and the Medical Staff bylaws.

6.1(b) These individuals shall discuss the matter informally with the Practitioner, emphasizing that if the behavior continues, more formal action will be taken to stop it. The identity of the individual who made the report of Undermining Behavior shall not be disclosed at this time, unless the Chief Executive Officer and President, after consulting with legal counsel, agree in advance that legal requirements or unusual circumstances make it appropriate to do so. The following guidelines shall be followed regarding the meeting:

(1) The initial approach should be collegial and designed to be helpful to the physician;

(2) The parties should emphasize that if the behavior continues, more formal action will be taken to stop it;

(3) Informal meetings shall be documented with a written summary of the meeting. This documentation shall be maintained in a confidential peer review file of the Practitioner;

(4) A follow-up letter to the physician shall state that the physician is required to behave professionally and cooperatively, along with a copy of this Hospital policy on Undermining Behavior; and

(5) Nothing herein shall be deemed to prohibit more formal corrective action as a result of a single incident should the President and/or the Chief Executive Officer determine that the seriousness of the incident justifies such action.

6.1(c) If an additional incident of Undermining Behavior occurs, or if the President or the Chief Executive Officer determines it to be necessary, the Chief Executive Officer and the President, **shall** meet with and advise the physician that such behavior is intolerable and must stop. This meeting constitutes the physician's final warning. It shall be followed with a letter reiterating the warning and summarizing the meeting. The Practitioner may prepare a written response to the letter. This documentation shall be maintained in the Practitioner's confidential peer review file. More formal corrective action may be pursued at this juncture if deemed warranted by the President and/or Chief Executive Officer.

6.1(d) Every meeting with the Practitioner shall include a review of the Hospital's policy against retaliation. Such discussions shall be explicitly documented

6.1(e) All meetings with the Practitioner shall be documented.

6.1(f) After each meeting with the Practitioner, a letter shall be sent to the Practitioner confirming the Hospital's and medical staff leadership's position – that the Practitioner is required to behave professionally and cooperatively, and which also shall include the potential consequences of continued non-compliance or retaliation against individuals the Practitioner believes to have reported the behavior in question.

7.1 DISCIPLINARY ACTION PURSUANT TO BYLAWS

7.1(a) A single additional incident of behavior that undermines a culture of safety, after the above process has been completed, shall result in initiation of formal disciplinary action pursuant to the medical staff bylaws. The Chief Executive Officer and President shall be responsible for presenting the history of behavior to the Medical Executive Committee.

7.1(b) Summary suspension may be appropriate pending this process, depending upon the seriousness of the offense, and after consultation with operations counsel.

7.1(c) The Medical Executive Committee must be fully advised of all of the previous meetings and warnings, if any, and must take them into account, so that it may pursue whatever action is necessary to cease the Undermining Behavior.

7.1(d) The Medical Executive Committee must take action or refer the matter to the Board with a recommendation as to action. This recommendation shall be processed as provided in the administrative corrective action section of the Medical Staff Bylaws. The Board will review and may initiate action if the Medical Executive Committee fails to take action, refer the matter or make a recommendation as to action regarding the matter.

7.1(e) Although the above outline is a suggested method of progressive counseling and discipline, nothing herein shall be deemed to require such progressive discipline in the event that the seriousness of the individual's behavior warrants immediate corrective action. A single egregious incident, including but not limited to physical or sexual harassment, a felony conviction, assault, a fraudulent act, stealing, damaging Hospital property or jeopardizing patient care may result in immediate corrective action. As such, if they deem it appropriate based upon the circumstances, the Hospital's Chief Executive Officer, President or Board Chairperson may initiate formal disciplinary action under the Bylaws for a single incident of Undermining Behavior without first resorting to the progressive disciplinary approach set forth herein.

7.1(f) The Hospital's Human Resource Director may be formally included as an ex-officio member of the applicable committee without vote. If the Human Resource Director is so included, the minutes of the applicable committee shall so indicate. To the extent possible, the Hospital's Human Resource Director should be advised of the action taken against a Practitioner resulting from a report of Undermining Behavior by a Hospital employee.

BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY POLICY
ADOPTED & APPROVED:

MEDICAL STAFF:

By: _____ _____
President Date

GOVERNING BOARD:

By: _____ _____
Chairperson Date

COMMUNITY REHABILITATION HOSPITAL NORTH:

By: _____ _____
President Date

APPROVED AS TO FORM:

By: _____ _____
Legal Counsel for Community Health Network Rehabilitation Hospital, LLC Date

APPROVED:

By: _____ _____
Group President Date

APPENDIX "D" –PROVIDER WELLNESS POLICY

It is the policy of this Hospital to properly review and act upon concerns that a provider as defined in the Medical Staff Bylaws, is suffering from an illness or impairment. The Hospital will conduct its review and act in accordance with pertinent state and federal law, including, but not limited to, the Americans With Disabilities Act. For purposes of this policy, impaired shall mean acute and ongoing physical, psychiatric, and emotional illness or injury, as well as health issues due to alcohol and drugs.

As part of the Hospital's commitment to the safe and effective delivery of care to patients, the Hospital and Medical Staff shall conduct education sessions concerning provider health and impairment issues, including illness and impairment recognition issues specific to providers ("at-risk" criteria).

1.1 REPORT & REVIEW

If any individual in the Hospital has a reasonable suspicion that a provider appointed to the Medical or APP Staff and/or with clinical privileges is impaired, the following steps shall be taken:

1.1(a) An oral or, preferably, a written report shall be given to the Chief Executive Officer or the President. The reporting individual shall otherwise keep the report and the facts related thereto confidential. The report shall include a description of the incident(s) that led to the belief that the provider may be impaired. The report must be factual. The individual making the report need not have proof of the impairment, but must state the facts leading to the suspicions. A provider who feels that he/she may be suffering from impairment may also make a confidential self-report.

1.1(b) Notwithstanding the foregoing, in the event that any person observes a provider who appears to be currently impaired by drugs or alcohol, that person shall report the events to the President and/or CEO immediately. The President and CEO may order an immediate drug or alcohol screen if, in their opinion, circumstances so warrant.

1.1(c) If, after discussing the incidents with the individual who filed the report, the Chief Executive Officer and President, or their respective designees, believe there is sufficient information to warrant further inquiry, the Chief Executive Officer and President, or their respective designees, may:

(1) Meet personally with the provider or designate another appropriate person to do so; and/or

(2) Direct in writing that a review be instituted and a report thereof be rendered by an ad hoc committee to be appointed by the MEC for this purpose. The MEC shall appoint an ad hoc committee of three (3) physicians to review the issue within five (5) days of receipt of the request.

1.1(d) In performing all functions hereunder, the Chief Executive Officer and President shall be deemed authorized agents of the MEC and the ad hoc committee and shall enjoy all immunity and confidentiality protections afforded under state and federal law.

1.1(e) Following a written request to review, the ad hoc committee shall review the concerns raised and any and all incidents that led to the belief that the provider may be impaired. The ad hoc committee's review may include, but is not limited to, any of the following:

(1) A review of any and all documents or other materials relevant to the review;

(2) Interviews with any and all individuals involved in the incidents or who may have information relevant to the review, provided that any specific inquiries made regarding the provider's health status are related to the performance of the provider's clinical privileges and Medical Staff duties and are consistent with proper patient care or effective operation of the Hospital;

(3) A requirement that the provider undergo a complete medical examination as directed by the ad hoc committee, so long as the exam is related to the performance of the provider's clinical privileges and Medical Staff duties and is consistent with proper patient care or the effective operation of the Hospital; and

(4) A requirement that the provider take a drug test to determine if the provider is currently using drugs illegally or abusing legal drugs.

1.1(f) The ad hoc committee shall meet informally with the provider as part of its review. This meeting does not constitute a hearing under the due process provisions of the Hospital's Medical Staff Bylaws or pertinent credentialing policy and is not part of a disciplinary action. At this meeting, the ad hoc committee may ask the provider health-related questions so long as they are related to the performance of the provider's clinical privileges and Medical Staff duties, and are consistent with proper patient care and the effective operation of the Hospital. In addition, the Committee may discuss with the provider whether a reasonable accommodation is needed or could be made so that the provider could competently and safely exercise his or her clinical privileges and the duties and responsibilities of Medical Staff appointment.

1.1(g) Based on all of the information reviewed, the ad hoc committee shall determine:

(1) Whether the provider is impaired, or what other problem, if any, is affecting the provider;

(2) Whether the provider would benefit from professional resources, such as counseling, medical treatment or rehabilitation services for purposes of diagnosis and treatment of the condition or concern, and if so, what services would be appropriate;

(3) If the provider is impaired, the nature of the impairment and whether it is classified as a disability under the ADA;

(4) If the provider's impairment is a disability, whether a reasonable accommodation can be made for the provider's impairment such that, with the reasonable accommodation, the provider would be able to competently and safely perform his or her clinical privileges and the duties and responsibilities of Medical Staff appointment;

(5) Whether a reasonable accommodation would create an undue hardship upon the Hospital, such that the reasonable accommodation would be excessively costly, extensive, substantial or disruptive, or would fundamentally alter the nature of the Hospital's operations or the provision of patient care; and

(6) Whether the impairment constitutes a "direct threat" to the health or safety of the provider, patients, Hospital employees, physicians or others within the Hospital. A direct threat must involve a significant risk of substantial harm based upon medical analysis and/or other objective evidence. If the provider appears to pose a direct threat because of a disability, the Committee must also determine whether it is possible to eliminate or reduce the risk to an acceptable level with a reasonable accommodation.

1.1(h) If the review produces sufficient evidence that the provider is impaired, the CEO shall meet personally with the provider or designate another appropriate individual to do so. The provider shall be told that the results of a review indicate that the provider suffers from an impairment that affects his/her practice. The provider should not be told who filed the report, and does not need to be told the specific incidents contained in the report.

1.1(i) If the ad hoc committee determines that there is a reasonable accommodation that can be made as described above, the Committee shall attempt to work out a voluntary agreement with the provider, so long as that arrangement would neither constitute an undue hardship upon the Hospital or create

a direct threat, also as described above. The Chief Executive Officer and President shall be kept informed of attempts to work out a voluntary agreement between the Committee and the provider, and shall approve any agreement before it becomes final and effective.

1.1(j) If the ad hoc committee determines that there is no reasonable accommodation that can be made as described above, or if the ad hoc committee cannot reach a voluntary agreement with the provider, the ad hoc committee shall make a recommendation and report to the MEC, through the President, for appropriate corrective action pursuant to the Bylaws. If the MEC's action would provide the provider with a right to a hearing as described in the Hospital's Medical Staff Bylaws or credentialing policy, all action shall be taken in accordance with the Fair Hearing Plan, and strict adherence to all state and federal reporting requirements will be required. The Chief Executive Officer shall promptly notify the provider of the recommendation in writing, by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to have waived the right to a hearing as provided in the Hospital's Medical Staff Bylaws or credentialing policy.

1.1(k) The original report and a description of the actions taken by the ad hoc committee shall be included in the provider's confidential file. If the initial or follow-up review reveals that there is no merit to the report, the same shall be noted on the report and no further action shall be taken. If the initial or follow-up review reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a separate portion of the provider's file and the provider's activities and practice shall be monitored until it can be established that there is, or is not, an impairment problem.

1.1(l) The Chief Executive Officer shall inform the individual who filed the report that follow-up action was taken, but shall not disclose confidential peer review information or specific actions implemented.

1.1(m) All parties shall maintain confidentiality of any provider referred for assistance, except as limited by law, ethical obligation, or when safety of a patient is threatened. Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussions of this matter with anyone outside those described in this policy.

1.1(n) In the event of any apparent or actual conflict between this policy and the bylaws, rules and regulations, or other policies of the Hospital or its Medical Staff, including the due process sections of those bylaws and policies, the provisions of this policy shall control.

1.1(o) Nothing herein shall preclude commencement of corrective action, including summary suspension under the Medical Staff Bylaws, or termination of any contractual agreements between the Hospital and the provider, including any employment agreement, in the event that the provider's continued practice constitutes a threat to the health or safety of patients or any person.

2.1 REHABILITATION & REINSTATEMENT GUIDELINES

2.1(a) Substance Abuse - If it is determined that the provider suffers from a drug or alcohol related impairment that could be reasonably accommodated through rehabilitation, the following are guidelines for rehabilitation and reinstatement:

(1) Hospital and Medical Staff leadership shall assist the provider in locating a suitable rehabilitation program. A provider who may benefit from counseling or rehabilitative services, but who is not believed to be impaired in his ability to competently and safely perform his/her clinical privileges or the duties of Medical Staff membership, may be referred for assistance while still actively practicing at the Hospital. In cases where the provider's ability is believed to be impaired, the provider shall be allowed a leave of absence if necessary. A provider who is determined to have an impairment which requires a leave of absence for rehabilitation shall

not be reinstated until it is established, to the satisfaction of the ad hoc committee, the MEC and the Board, that the provider has successfully completed a program in which the Hospital has confidence.

(2) Upon sufficient proof that a provider who has been found to be suffering from an impairment has successfully completed a rehabilitation program that provider may be considered for reinstatement to the Medical Staff.

(3) In considering an impaired provider for reinstatement, the Hospital and Medical Staff leadership must consider patient care interests paramount.

(4) The ad hoc committee must first obtain a letter from the physician director of the rehabilitation program where the provider was treated. The provider must authorize the release of this information. That letter shall state:

(i) Whether the provider is participating in the program;

(ii) Whether the provider is in compliance with all of the terms of the program;

(iii) Whether the provider attends AA meetings or other appropriate meetings regularly (if appropriate);

(iv) To what extent the provider's behavior and conduct are monitored;

(v) Whether, in the opinion of the director, the provider is rehabilitated;

(vi) Whether an after-care program has been recommended to the provider and, if so, a description of the after-care program; and

(vii) Whether, in the director's opinion, the provider is capable of resuming medical practice and providing continuous, competent care to patients.

(5) The provider must inform the ad hoc committee of the name and address of his or her primary care physician, and must authorize that physician to provide the Hospital with information regarding his or her condition and treatment. The ad hoc committee has the right to require an opinion from other physician consultants of its choice.

(6) From the primary care physician the ad hoc committee needs to know the precise nature of the provider's condition, and the course of treatment as well as the answers to the questions posed above in (4)(e) and (g).

(7) Assuming all of the information received indicates that the provider is rehabilitated and capable of resuming care of patients, the ad hoc committee, MEC and the Board shall take the following additional precautions when restoring clinical privileges:

(i) The provider must identify a another provider who is willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability; and

(ii) The provider shall be required to obtain periodic reports for the ad hoc committee from his or her primary physician-for a period of time specified by the Chief Executive Officer-stating that the provider is continuing treatment or therapy, as appropriate, and that his or her ability to treat and care for patients in the Hospital is not impaired.

(8) The provider's exercise of clinical privileges in the Hospital shall be monitored by a physician appointed by the MEC or President. The nature of that monitoring shall be determined by the ad hoc committee after its review of all of the circumstances.

(9) The provider must agree to submit to an alcohol or drug screening test (if appropriate to the impairment) at the request of the Chief Executive Officer or designee, the Chairperson of the ad hoc committee.

(10) All requests for information concerning the impaired provider shall be forwarded to the Chief Executive Officer for response.

2.1(b) Physical, Psychiatric or Emotional Illness - If it is determined that the provider suffers from an acute or ongoing physical, psychiatric, or emotional illness or injury that is not drug or alcohol related and could be reasonably accommodated through rehabilitation or treatment, the following are guidelines for rehabilitation or treatment and reinstatement:

(1) If applicable, the Hospital and Medical Staff leadership shall assist the provider in locating a suitable rehabilitation program or treatment plan. A provider who may benefit from counseling or rehabilitative services, but whose illness or injury is not believed to interfere with his ability to competently and safely perform his/her clinical privileges or the duties of Medical Staff membership, may be referred for assistance while still actively practicing at the Hospital. In cases where the provider's ability is believed to be undermined, the provider shall be allowed a leave of absence if necessary. A provider who is determined to have an illness or injury which requires a leave of absence for rehabilitation or treatment shall not be reinstated until it is established, to the satisfaction of the committee, the MEC and the Board, that the provider has successfully completed any necessary rehabilitation or treatment in which the Hospital has confidence.

(2) Upon sufficient proof that a provider who has been found to be suffering from an illness has successfully completed treatment or has been cleared for return to practice by his/her treating physician (as applicable), that provider may be considered for reinstatement to the Medical Staff.

(3) In considering a provider for reinstatement, the Hospital and Medical Staff leadership must consider patient care interests paramount.

(4) If requested by the committee, the provider must provide the name and address of his or her primary care physician, and must authorize that physician to provide the Hospital with information regarding his or her condition and treatment. The committee has the right to require an opinion from other physician consultants of its choice.

(5) Assuming all of the information received indicates that the provider is rehabilitated or recovered and capable of resuming care of patients, the committee, MEC and the Board may take the following additional precautions when restoring clinical privileges:

(i) The provider must identify another provider who is willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability; and

(ii) The provider may be required to obtain periodic reports for the committee from his or her primary physician, for a period of time specified by the Committee, stating that the provider is continuing treatment or therapy, as appropriate, and that his or her ability to treat and care for patients in the Hospital is not impaired.

(6) The provider's exercise of clinical privileges in the Hospital shall be monitored by a physician appointed by the MEC or President. The nature of that monitoring shall be determined by the committee after its review of all of the circumstances.

(7) All requests for information concerning the impaired provider shall be forwarded to the Chief Executive Officer for response.

PROVIDER WELLNESS POLICY
ADOPTED & APPROVED:

MEDICAL STAFF:

By: _____ _____
President Date

GOVERNING BOARD:

By: _____ _____
Chairperson Date

COMMUNITY REHABILITATION HOSPITAL NORTH:

By: _____ _____
Chief Executive Officer Date

APPROVED AS TO FORM:

By: _____ _____
Legal Counsel for Community Health Network Rehabilitation Hospital, LLC Date

APPROVED:

By: _____ _____
Group President Date