MEMORIAL HOSPITAL

MEDICAL STAFF BYLAWS

Governance and Credentialing Manual

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DEFINITIONS

The following definitions, unless otherwise expressly indicated, apply throughout the Medical Staff Bylaws. The Medical Staff Bylaws include: (1) the Governance and Credentialing Manual, and (2) the Corrective Action and Fair Hearing Manual. The use of capitalization when defining terms is intended for convenience purposes only and shall not affect the meaning or interpretation of such terms.

"Administration" or **"Hospital Administration"** refers to and includes the Hospital President, the Hospital President's senior management team, and each of their authorized designees.

"Administrative Action" means any determination, recommendation or action taken by or on behalf of the Hospital Board of Directors or Medical Staff, or their respective designees, that are not professional review actions, but instead, are made or taken without a prior hearing for reasons related to objective administrative circumstances, as set forth in these Medical Staff Bylaws."

"Advanced Practice Professional" or **"APP"** means any individually licensed or certified health care provider (excluding a Physician, Dentist, Oral Surgeon, or Podiatrist) who: (a) has an independent or dependent scope of practice, (b) is authorized by the Governing Board to exercise specified Clinical Privileges within the Hospital in a manner that is consistent with the provider's scope of practice, and (c) is therefore credentialed through the Medical Staff credentialing process. By way of example, when the foregoing conditions are satisfied, APPs may include but are not limited to: advanced practice registered nurses, physician assistants, certified registered nurse anesthetists, physical therapists, licensed clinical social workers, and psychologists. For purposes of these Bylaws, APPs may additionally include licensed physician residents, who do not otherwise meet the requirements for Medical Staff Membership and/or Clinical Privileges at the Hospital, but who are approved to provide "moonlighting" services at the Hospital.

"Allied Health Practitioner" or **"AHP"** means any individually licensed or certified health care provider (excluding a Physicians, Dentist, Oral Surgeon, Podiatrist or APPs) who: (a) has a strictly dependent scope of practice, (b) is credentialed through the Hospital's Human Resources Department or other designated Hospital Department, and (c) is not eligible to receive or exercise specified Clinical Privileges within the Hospital.

"Applicant" means any Physician, Dentist, Oral Surgeon, Podiatrist, or eligible APP applying for initial appointment to the Medical Staff and/or for Clinical Privileges at the Hospital, as applicable.

"Beacon Health" or **"System"** means the Indiana not-for-profit and tax-exempt health system that owns and operates Hospital and serves patients throughout Northern Indiana and Southwest Michigan.

"Bylaws, Policies, and Procedures" shall refer to and include all applicable System, Hospital, and Medical Staff Bylaws, Rules, Regulations, and Policies.

"Chief Executive Officer" or **"CEO"** means the president of the System.

"Chief of Staff" means the person who is elected by the Medical Staff to serve as the principal official and chief administrative officer of the Medical Staff.

“Clinical Privileges” means the permission granted to a Practitioner by the Governing Board to render specific patient care services within the Practitioner's lawful scope of practice to patients at the Hospital, and permission to efficiently use Hospital resources necessary to exercise granted Clinical Privileges.

“Contact” refers to particular Practitioner contacts with the Hospital and/or their patients that may be tracked and/or otherwise considered by the Governing Board and Medical Staff in relation to the placement of Practitioners into appropriate Medical Staff categories. Contacts include an inpatient admission or consultation, referral to an inpatient admission service, evaluation and treatment of an emergency department patient, an inpatient or outpatient surgical procedure, a diagnostic procedure interpretation at the Hospital, participation, and attendance on a Medical Staff Committee, undertaking an assigned Medical Staff assignment or duty, or other elements of Medical Staff participation that are tracked by the Medical Staff office. Pursuant to individual request and presentation of sufficient documentation, other patient care activity may hereafter be designated by the MEC as meeting the contact requirement.

“Credentials Committee” means the Medical Staff's standing Peer Review Committee responsible for undertaking credentialing review, evaluation, and recommendations concerning Applicants and Practitioners, and also for overseeing and implementing the Medical Staff's processes for OPPE and for FPPE (for new or additional Clinical Privileges.

“Days” unless otherwise indicated, means “calendar days” (i.e. including Saturday, Sunday, and legal holidays) unless the due date falls on a Saturday, Sunday, or legal holiday, in which case the due date shall be the first (1st) day immediately following the day that is not a Saturday, Sunday, or legal holiday.

“Department” means a clinical department within the Medical Staff governance structure as set forth and further described in the Bylaws.

“Dentist” means a duly licensed Dentist.

“Direct Economic Competition” means those situations or circumstances when two individuals share the same Clinical Privileges at a Hospital and/or when their health care practices substantially overlap such that the individuals compete to provide the same type of health care services to the same population of patients.

“Ex Officio” means service as a Member of a committee or other designated body by virtue of an office or position held, such service being without voting rights unless otherwise specified.

“Focused Professional Practice Evaluation” or **“FPPE”** refers to the Peer Review evaluation, for privilege-specific competency, of Applicants seeking Clinical Privileges at a Hospital and of Practitioners who have requested to receive new or additional Clinical Privileges; and also refers to the Peer Review evaluation of Practitioners when specific performance-related concerns implicating patient safety and/or quality of care are identified.

“Good Standing” means a Practitioner who, during the current term of appointment to the Medical Staff and/or term of Clinical Privileges, continues to maintain all qualifications for Medical Staff Membership, Clinical Privileges, and assigned category, as applicable, and is in compliance with all responsibility’s attendant to Medical Staff Membership and Clinical Privileges, as applicable.

“Governing Board” or **“Board”** means the Board of Directors of the Hospital.

“Hospital” means Memorial Hospital of South Bend, Inc., including all locations subject to its state-issued hospital license.

“Hospital President” means the individual appointed by the Governing Board to act on its behalf in the overall management of the Hospital.

“Law” shall refer to all applicable Federal and State laws, rules, and regulations, as well as all pertinent Accreditation Standards.

“Medical Executive Committee” or **“MEC”** means the executive committee of the Medical Staff, which shall have a composition and shall undertake such functions as set forth in the Medical Staff Bylaws.

“Medical Staff” means all Physicians, Dentists, Oral Surgeons, Podiatrists, and APPs who have been granted Membership on the Medical Staff by the Governing Board.

“Medical Staff Bylaws” or **“Bylaws”** means the Medical Staff Bylaws of the Hospital's Medical Staff, which include both the Governance and Credentialing Manual and the Corrective Action and Fair Hearing Manual.

“Member” means any Physician, Dentist, Oral Surgeon, Podiatrist or APP who has been granted Membership on the Medical Staff by the Governing Board.

“Membership” means the participation as a Member of the Medical Staff, and which therefore includes, and is expressly subject to, all attendant requirements, rights, and obligations.

“Ongoing Professional Practice Evaluation” or **“OPPE”** means the systematic and ongoing Peer Review process used to evaluate and confirm the current competency of those Practitioners with Clinical Privileges at the Hospital.

“Oral Surgeon” means a duly licensed dental specialist who has not only completed four (4) years of dental school but has also completed an oral and maxillofacial surgery residency approved by the Commission of Dental Accreditation of the American Dental Association.

“Peer Review” refers to any and all activities and conduct of Peer Review Committees ultimately intended, either directly or indirectly, to further the quality of patient care provided at the Hospital. Peer Review, as defined by Indiana's Peer Review Statute, includes the evaluation of qualifications of health care providers, patient care rendered by health care providers, and complaints or concerns regarding the professional conduct or competency of health care providers, which affects or could affect adversely the health or welfare of a patient or patients. Peer Review at the Hospital includes, but is not necessarily limited to, the credentialing process, the corrective action and fair hearing process, quality assurance and performance improvement activities, utilization review activities, and all other review processes that are consistent with Peer Review in Indiana.

“Peer Review Committee” means a committee of the Medical Staff or Hospital that is formed in a manner consistent with Indiana and Federal law and that is responsible, in full or in part, for engaging

in Peer Review. By way of example, Peer Review Committees at the Hospital include the Governing Board, the Medical Staff (as a whole), the MEC, the Credentials Committee, and any other committee of the Medical Staff and/or Hospital that is tasked, in full or in part, with engaging in Peer Review. Peer Review Committees include not only those serving as members of the committees, but also their employees, designees, representatives, agents, attorneys, consultants, investigators, experts, assistants, clerks, staff and any other persons or organizations, whether internal or external, who assist the committee in performing its Peer Review functions. All reports, studies, analyses, documents, materials, determinations, deliberations, recommendations, and other similar communications that are authorized, requested, or reviewed by a Peer Review Committee or persons acting on behalf of a Peer Review Committee shall be treated as strictly confidential and not subject to discovery nor admissible as evidence consistent with, and to the full extent permitted by, those protections afforded under applicable Indiana law. If a Peer Review Committee or its designee deems appropriate, assistance may be obtained, in an appropriate manner, from other Peer Review Committees, other committees, individuals or organizations inside or outside the Hospital. Each Peer Review Committee of the Hospital and Medical Staff hereby claims all privileges, protections, and immunities available to such committee.

"Physician" means a duly licensed allopathic or osteopathic Physician.

"Podiatrist" means a duly licensed Podiatrist.

"Practitioner" means any Physician, Dentist, Oral Surgeon, Podiatrist, or APP who has been granted Medical Staff Membership and/or Clinical Privileges at the Hospital.

"Professional Review Action" means an action or recommendation of a Peer Review Committee, taken in the course of a professional review activity, based upon a Practitioner's competence or professional conduct (which conduct affects or could adversely affect the health or welfare of a patient or patients), and which adversely affects (or may adversely affect) the Practitioner's Medical Staff Membership and/or Clinical Privileges. Such term includes a formal decision of a Peer Review Committee not to take an action or make a recommendation described in the previous sentence.

"Section" means a designated clinical section within a Department, as applicable, when made a part of the Medical Staff governance structure, as set forth and further described in the Bylaws.

"Special Notice" means any notice required to be given under the Medical Staff Bylaws, unless otherwise stated, that is designated as a "Special Notice." Such notice shall be in writing and shall be deemed given when personally delivered or sent by prepaid United States certified mail with return receipt requested, traceable courier services, confirmed email communication, or confirmed facsimile. All Special Notices shall be considered received on the date actually received if given by personal delivery or traceable courier service, or on the date shown as received on the certified mail receipt, email confirmation, or fax confirmation sheet if given by such method. A refusal to accept delivery of service shall constitute effective delivery as of the date of any such refusal.

"Vice President Medical Staff Affairs" or **"VPMA"** means the individual serving as the Hospital's liaison officer to the Hospital and Medical Staff (if such individual has been appointed by the Hospital), who assists with the Medical Staff's performance improvement, quality assurance activities, and the clinical organization of the Medical Staff. In the event there is no VPMA at the Hospital, the functions prescribed in these Bylaws shall default to the Chief of Staff (unless otherwise specified).

Words used in the Medical Staff Bylaws shall be read interchangeably as the masculine or feminine gender and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of the Bylaws.

ARTICLE I

PURPOSES OF THE MEDICAL STAFF

The purposes of the Medical Staff shall be to:

(a) Establish, maintain, amend, and enforce Medical Staff Bylaws for the self-governance of the Medical Staff, which shall be reviewed periodically and revised as necessary subject to final review and approval by the Governing Board;

(b) Provide oversight for the quality of patient care, treatment, and services provided by Practitioners at the Hospital;

(c) Provide an environment where patients admitted to or treated in or by any of the facilities, Departments, or Sections of the Hospital receive appropriate, timely, quality medical care without discrimination on the basis of race, national origin, handicap, religion, color, creed, sex, age, financial status or other legally protected status;

(d) Promote an acceptable level of professional performance of all Practitioners authorized to practice in the Hospital by the Governing Board, through the appropriate evaluation of Practitioners applying or reapplying for Medical Staff Membership and/or Clinical Privileges, as applicable, through delineating the scope of Clinical Privileges that will be granted to Practitioners, and through the ongoing review and evaluation of each Practitioner's performance in the Hospital;

(e) Provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed among the Medical Staff and Governing Board, through their appointed members and/or designees;

(f) Carry out Peer Review activities, both alone and in conjunction with Hospital Administration, as agents of the Governing Board, in making recommendations for the credentialing and recredentialing of Applicants and Practitioners, in setting standards for and reviewing the efficient and effective use of Hospital resources, in investigating professional conduct and/or clinical concerns, and in carrying out other Peer Review functions in the furtherance of quality of care;

(g) Provide an appropriate educational setting that will lead to continuous advancement in professional knowledge and skill; and

(h) Establish, maintain, and enforce rules, regulations, policies, and procedures to ensure that the needs and concerns expressed by Members of the Medical Staff, regardless of practice or location, are given due consideration.

ARTICLE II

ELIGIBILITY FOR MEDICAL STAFF MEMBERSHIP AND/OR CLINICAL PRIVILEGES

2.1. Nature of Medical Staff Membership and Clinical Privileges

(a) Membership on the Medical Staff is a privilege, which shall be extended only to those Physicians, Dentists, Oral Surgeons, Podiatrists, and APPs who have demonstrated a high level of professional competence and have met, and continue to meet, the qualifications, standards and requirements set forth in the Medical Staff Bylaws. No Physician, Dentist, Oral Surgeon, Podiatrist, or APP shall provide services to patients in the Hospital unless he or she has been appropriately granted Clinical Privileges to do so.

(b) A doctor of medicine (MD) or osteopathic medicine (DO) shall be responsible for the care of each patient with respect to any medical or psychiatric condition that is not within the scope of practice and Clinical Privileges of a non-physician. Neither the Hospital nor the Medical Staff shall discriminate on the basis of race, national origin, handicap, religion, color, creed, sex, age, financial status or other legally protected status that does not affect a Practitioner's ability to safely and reasonably provide care to patients with or without reasonable accommodation.

(c) Any Practitioner who is engaged, individually or through a legal entity, by the Hospital as an independent contractor or employed Practitioner to provide specified clinical services at the Hospital must possess Medical Staff Membership and Clinical Privileges, as applicable, as recommended by the Medical Staff and granted by the Governing Board. The Membership and/or Clinical Privileges of such Practitioners may be subject to Administrative termination to the extent such termination is made a part of the applicable employment or independent contractor agreement.

2.2. Qualifications for Medical Staff Membership and Clinical Privileges

2.2.1. General Standards

Only those Physicians, Dentists, Oral Surgeons, Podiatrists, and APPs who can document appropriate licensure, certification, background, education, training, experience, professional competence, health status, reputation, character, judgment, and ability to work with others, as well as adherence to the ethics of their professions and to the Bylaws, Policies, and Procedures shall be eligible for Medical Staff Membership and/or the granting of Clinical Privileges, as applicable. Applicants may also be required to meet the requirements of any prevailing Medical Staff Development Plan and/or Institutional Needs assessment or process adopted by the Governing Board and in effect at the time of application.

2.2.2. Basic Qualifications

With the exception of Honorary Staff, only those Applicants and Practitioners who can continuously demonstrate or provide evidence of the following qualifications to the satisfaction of the MEC and Governing Board will be eligible for Medical Staff Membership and/or the granting of Clinical Privileges, as applicable:

(a) Current and valid, non-probationary and unrestricted Indiana license applicable to his or her profession;

(b) Current, valid, and unrestricted Drug Enforcement Administration ("DEA") registration (with appropriate Indiana registration) and Indiana Controlled Substances registration, unless such registrations, in the discretion of the MEC, are not required by, or attendant to, the Clinical Privileges sought or maintained by a Practitioner;

(c) Eligibility to participate in federal and Indiana governmental health care programs, including but not limited to Medicare and Medicaid;

(d) Absence of: (i) any felony criminal conviction (or pending charge or indictment if an Applicant), or (ii) any misdemeanor criminal conviction (or pending charge of a new Applicant) that would violate the pertinent requirements for participation in the Medicare program or Indiana Medicaid Program;

(e) Professional liability insurance in the coverage, scope, amounts and/or limits established by the Governing Board;

(f) Acceptable character, competence, training, experience, background, and judgment;

(g) Compliance with all applicable guidelines and opinions set forth in the Code of Medical Ethics of the American Medical Association, the Code of Ethics of the American Osteopathic Association, the Principles of Ethics and Code of Professional Conduct of the American Dental Association, the Principles of Ethics of the American Podiatric Association and all other applicable ethical guidelines of the Applicant's or Practitioner's licensing body;

(h) Evidence of satisfactory clinical performance within the preceding thirty-six (36) months (in private practice and/or during the period of the Applicant's training program if the Applicant is an initial applicant and graduated from such training program less than thirty (36) month prior to the application) with an active clinical practice in the area in which Clinical Privileges are sought and which is adequate to meet the Hospital's current criteria for clinical competence;

(i) Acceptable professional liability case frequency, judgment or settlement history;

(j) Subject to applicable Law, Physical and mental ability and health status necessary to perform the obligations of Medical Staff Membership and the requested Clinical Privileges, as applicable, to the satisfaction of the Hospital and Medical Staff;

(k) Appropriate written and verbal communication skills;

(l) Willingness and ability to properly discharge the responsibilities established by the Hospital, Governing Board and Medical Staff; and

(m) Board eligibility or certification, as applicable, as required by Section 2.2.3 of these Bylaws;

(n) Absence of any prior adverse clinical privileging actions, including but not limited to restrictions, suspensions, and/or revocations of medical staff membership and clinical privileges at the Hospital or other hospitals, ambulatory surgery centers, or other health care facilities, unless the Governing Board, following recommendation from the MEC, determines (in its sole discretion) to make an exception. Any refusal by the MEC or Governing Board to make such an exception shall constitute an Administrative Action;

(o) Absence of any prior employment termination by, or resignation from, a System affiliate or by any other legal entity that resulted from or was related to, in full or in part, concerns by the employer involving the Applicant's or Practitioner's professional competency and/or professional conduct (irrespective of whether the employment resulted in a resignation or separation agreement, or of a termination, whether such termination was designated as "for cause" or "without cause"), unless the Governing Board, following recommendation from the MEC, determines (in its sole discretion) to make an exception. Any refusal by the MEC or Governing Board to make such an exception shall constitute an Administrative Action; and

(p) Absence of any exclusive professional services agreement, discontinuance, or closure that would preclude Medical Staff Membership and/or Clinical Privileges, as applicable, as set forth Article XII, below.

No Applicant or Practitioner shall be entitled to Membership on the Medical Staff and/or Clinical Privileges in the Hospital, as applicable, merely by virtue of: (a) licensure in Indiana or in any other state; (b) certification, fellowship, or membership in any professional organization, specialty body or society; or (c) employment by any System affiliate or other entity, or (d) by virtue of holding similar Clinical Privileges at any other health care organization.

2.2.3. Board Certification

(a) All Physician, Dentist, Oral Surgeon, and Podiatrist Applicants for Medical Staff Membership and Clinical privileges must be board certified in a specialty that

is reasonably related, in the discretion of the MEC, to the Clinical Privileges they seek.

(b) As an exception to subsection (a), above, Applicants to the Medical Staff (who, for clarity, are initial Applicants to the Medical Staff) may be board eligible when they initially apply for Medical Staff Membership and Clinical Privileges in a specialty that is reasonably related, in the discretion of the MEC, to the Clinical Privileges they seek. Such Applicants, however, must become board certified in such specialty as soon as reasonably possible, but in all instances, within the time period required by the Applicant's applicable specialty board for certification following eligibility. If the specialty board does not identify a maximum period of time for certification following eligibility, then the Applicant is hereby required to achieve certification within five (5) years of initial eligibility. A failure to timely achieve board certification, as required by this subsection, shall result in the immediate and automatic termination of Medical Staff Membership and Clinical Privileges. Such termination shall constitute an Administrative Action.

(c) As an additional exception to subsection (a), above, if an Applicant has completed his/her residency or fellowship training in the twelve (12) month period prior to applying to the Medical Staff, and the pertinent specialty board expressly requires a defined period of clinical practice prior to board eligibility, then such Applicants may apply for Medical Staff Membership and Clinical Privileges, but must then achieve board eligibility within two (2) years of initial appointment to the Medical Staff. Thereafter, the Applicant must achieve board certification within the time requirements set forth in the preceding subsection (b). A failure to timely achieve board eligibility or certification, as required by this subsection, shall result in the immediate and automatic termination of Medical Staff Membership and Clinical Privileges. Such termination shall constitute an Administrative Action.

(d) Acceptable specialty boards include those boards recognized by the American Board of Medical Specialties and the American Osteopathic Association, as well as the American Boards of Podiatric Surgery and Podiatric Medicine, the American Board of Multiple Specialties in Podiatry, or any other specialty board approved by the Governing Board upon recommendation of the MEC. Board certification must be in a specialty that is reasonably related to the Clinical Privileges sought by or granted to the Applicant or Member.

(e) Physicians, Dentists, Oral Surgeons and Podiatrists who: (i) were initially appointed to the Medical Staff before [March 26, 2024] (the "Grandfather Date"), who were not board certified at the time of such appointment, and who have maintained continuous and uninterrupted Medical Staff Membership and/or Clinical Privileges since this date, or (ii) were initially appointed to the Medical Staff at a time when no specialty board existed that was reasonably related, in the discretion of the MEC, to the Clinical Privileges they sought, and who have maintained continuous and uninterrupted Medical Staff

Membership and/or Clinical Privileges since this date shall not be required to become board certified (or maintain board certification) as a condition of continued Medical Staff Membership and/or Clinical Privileges, provided that these Members otherwise meet the established competency requirements and other relevant criteria established by the Medical Staff and Governing Board. All other Physicians, Dentists, Oral Surgeons, and Podiatrists who are Applicants or Members must meet the board certification requirements set forth in this Section 2.2.3.

(f) Except for those Members who were appointed to the Medical Staff before the Grandfather Date and who have maintained continuous and uninterrupted Medical Staff Membership and Clinical Privileges since this date, all Applicants and Members must not only satisfy the Board Certification requirement in this Section 2.2.3, but must also remain board certified as an ongoing condition of Medical Staff Membership and/or Clinical Privileges unless an express exception is made as provided herein.

(g) In the event a Physician, Dentist, Oral Surgeon, or Podiatrist applies for new or additional Clinical Privileges that (in the discretion of the MEC or Governing Board) relate to a clinical specialty that is different than the Member's current specialty, or are otherwise inconsistent with or beyond the scope of the Member's current clinical practice, then the Member shall be required to satisfy the board certification requirements set forth in this Section 2.2.3.

(h) In exceptional circumstances, the MEC may recommend, and the Governing Board may approve, a temporary or permanent waiver of the Board eligibility and/or Board Certification requirements required by this Section 2.2.3. Any recommendation in this regard should be supported by particular documentation and/or other information, which demonstrates good cause for making an exception, and which includes sufficient evidence of training, education, competence, experience, and ability to safely perform the Clinical Privileges requested. The determination to make an exception pursuant to this subsection (h) shall relate only to the particular Clinical Privileges sought and granted (or their future equivalent). Such an exception shall not constitute an exception as to any new or additional Clinical Privileges that are thereafter sought.

(i) All determinations made by the MEC and Governing Board with respect to application or waiver of the board certification requirements, as set forth in and contemplated this Section 2.2.3, shall constitute Administrative Actions, and as such, shall not entitle the Applicant or Member subject of the request to any fair hearing or other rights to due process.

2.3. Responsibilities of Medical Staff

As initial and ongoing conditions for appointment/reappointment to the Medical Staff and for Clinical Privileges at the Hospital, as applicable, each Applicant and Practitioner shall:

(a) Provide appropriate, timely, quality medical, dental or podiatric care without discrimination on the basis of race, national origin, handicap, religion, color, creed, sex, age, financial status or other legally protected status;

(b) Submit to and meaningfully participate in focused, ongoing, and periodic Peer Review of professional competence and skill, as well as quality assurance and improvement activities, functions, and responsibilities, as may be reasonably requested or otherwise required by the Bylaws, Policies, and Procedures, whether undertaken by the System, Hospital, or Medical Staff internally or externally;

(c) Consistent with subsection (b), above, comply with all Hospital, Medical Staff, MEC, Department, Section, or other Medical Staff committee meeting requests, documentation requests, personal appearance requests, and any requests made to undergo physical or mental health examination if requested as part of a Medical Staff FPPE, investigation, or secondary to any reasonable concern related to the Applicant's or Practitioner's potential impairment and/or ability to safely exercise Clinical Privileges or practice his or her profession;

(d) Accept committee assignments on a reasonable basis, comply with any attendance requirements established by the Bylaws, Policies, and Procedures, and otherwise make a good faith effort to attend Medical Staff, Department, Section and Committee meetings;

(e) Comply with all current and applicable Bylaws, Policies, and Procedures, and the Law, including but not limited to, the prohibition on inappropriate fee-splitting arrangements;

(f) Meaningfully participate in applicable System and Hospital accreditation, licensing, and compliance education activities; meaningfully participate in applicable Hospital risk management initiatives and activities, and when reasonably requested, meaningfully and timely appear for and participate in applicable Hospital risk-management related meetings;

(g) Successfully complete, over the three year period following initial appointment or reappointment, as applicable, the minimum amount and type of Category 1 Continuing Medical Education ("CME") required by the Practitioner's specialty board, and must provide reliable evidence of same. In the event the Practitioner is not board certified, or if the Practitioner's specialty board does not require CME, then the Practitioner must complete a minimum of 75 hours of Category 1 Continuing Medical Education ("CME") that directly relates to the Clinical Privileges sought or held by the Practitioner;

(h) Serve on the Hospital's Emergency Department call roster (if eligible) as established by the Chairperson(s) of the respective Department(s) and MEC, and fulfill such obligations in a manner that is consistent with the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) and related provisions, as implemented by the applicable Hospital and the Medical Staff;

(i) Comply with the Hospital's communicable disease surveillance and prevention program, including but not limited to, all vaccinations required by the Bylaws, Policies, and Procedures, or by the Law;

(j) Participate in and successfully complete in a timely manner any System, Hospital, or Medical Staff sponsored or required training programs, including but not limited to those related to electronic medical record (EMR) and related clinical system implementation, pass any related program examination or opt-out examination, and submit required program documentation; Applicants and Members shall comply with all rules and regulations, and other applicable policies of the Medical Staff and Hospital related to such training programs, including but not limited to implementation and use of EMR systems; Members shall utilize the EMR (to the fullest extent the EMR is available) rather than hard-copy documentation/charting;

(k) Report to the Hospital President and VPMA, by way of the Medical Staff Office, **<u>within five (5) business days</u>** of receiving notice of any of the following:

(i) The initiation of any challenge or investigation by any state's Medical Licensing Board, other applicable licensing board, or other governmental agency of any professional license or certification and the scope and nature of any charges related to the challenge or investigation;

(ii) The initiation of any investigation by the Office of the Inspector General (OIG), Centers for Medicare and Medicaid Services (CMS) or any other state or federal agency, including the scope and nature of any charges relating to the investigation, including any change in eligibility with third-party payers or participation in governmental health care programs, including Medicare and Medicaid, and any sanctions imposed or recommended by the OIG or CMS, and/or the receipt of a professional review organization citation and/or quality denial letter concerning alleged quality problems in patient care;

(iii) The initiation of any challenge or investigation by the DEA or any State regarding, or the voluntary or involuntary relinquishment of, any state-controlled substance license or DEA registration;

(iv) The involuntary resignation or termination of medical staff membership or clinical privileges at another hospital, ambulatory surgery center, or health care facility (for clarity, "involuntary" in this

paragraph additionally includes a voluntary termination or resignation that occurs under the threat of, or to avoid, an involuntary investigation, action and/or termination);

(v) The involuntary limitation, reduction or loss of medical staff membership or clinical privileges at another hospital, ambulatory surgery center, or health care facility;

(vi) Receiving an adverse judgment, or upon the monetary settlement of, a professional liability action, including the parties thereto and related allegations;

(vii) The investigation, arrest, indictment or conviction with regard to any felony or criminal misdemeanor (minor traffic violations are not required to be reported; however, traffic violations involving (or alleging to have involved) drugs, alcohol, or operating a vehicle while intoxicated are not considered "minor traffic violations" for purposes of these Bylaws and must be reported); or

(viii) The suspension or termination of any professional liability insurance coverage or the failure to maintain such coverage at the scope, level or amount as determined by the Governing Board.

(l) All Applicants and Practitioners shall additionally provide (or shall be provided in the discretion of the Hospital) the Hospital's Medical Staff Office with (and shall update as may become necessary) an email address that is accurate, current, private, and secure.

2.4. Conditions and Duration of Membership/Clinical Privileges

(a) Initial appointments and reappointments to the Medical Staff and the granting of Clinical Privileges shall be made by the Governing Board. The Governing Board shall act on appointments, reappointments, restrictions, or revocations of Membership and/or Clinical Privileges after there has been a determination/recommendation from the Medical Staff as provided in the Medical Staff Credentialing Manual or Corrective Action and Fair Hearing Manual, except as otherwise provided for in these Bylaws.

(b) Medical Staff Membership and Clinical Privilege appointments shall be for a period established by the Governing Board up to a maximum of three (3) years. The MEC and/or Governing Board may, in their discretion, approve a period of appointment that is less than three (3) years. The approval and imposition of a reduced period of appointment shall constitute an Administrative Action.

(c) Appointments to the Medical Staff shall confer on the Applicant/Practitioner only such Clinical Privileges as have been granted by the Governing Board in accordance with the Medical Staff Bylaws.

(d) Every application for Medical Staff Membership and/or for Clinical Privileges at the Hospital shall be signed by the Applicant/Practitioner. By submitting an application, each Applicant/Practitioner acknowledges his or her obligation to provide continuous care and supervision of his or her patients and to abide by all applicable Bylaws, Policies, and Procedures and the Law.

2.5. Ethics and Ethical Relationships

Acceptance of Medical Staff Membership and/or Clinical Privileges shall constitute the Practitioner's agreement to strictly abide by all applicable guidelines and opinions set forth in the Code of Medical Ethics of the American Medical Association, the Code of Ethics of the American Osteopathic Association, the Principles of Ethics and Code of Professional Conduct of the American Dental Association, the Principles of Ethics of the American Podiatric Association and all other applicable ethical guidelines of the Practitioner's licensing body.

2.6. Conflict of Interest

A conflict of interest arises when there is a divergence between a Practitioner's private interests and his/her professional obligations pursuant to the Bylaws, Policies, and Procedures. No Practitioner shall participate in a Medical Staff committee deliberation or vote, nor take any action in his or her capacity as a Medical Staff Officer, Chairperson, or in any other Medical Staff leadership capacity, if the Practitioner has (a) an actual conflict of interest or (b) a potential conflict of interest sufficient to render the Practitioner incapable of making a determination that is reasonably based upon the pertinent circumstances and that is in the best interests of patient safety, the Medical Staff, the Hospital, and the System.

(a) An actual conflict of interest exists if a Practitioner: (a) is the Practitioner under review (or is a first degree relative or spouse of such Practitioner) or (b) has an admitted or documented material bias against the Practitioner subject of review. All actual conflicts of interest shall be disclosed to the applicable Medical Staff committee, Committee chairperson, Chief of Staff, Hospital President, and/or VPMA.

(b) Potential conflicts of interest include the following:

(i) A Practitioner was directly involved in rendering clinical care to the patient subject of review, even though the Practitioner is not the practitioner subject of the review;

(ii) A Practitioner was the recipient, subject, or victim of the alleged act or omission;

(iii) A Practitioner previously voted on the same issue/matter in connection with another Medical Staff committee;

(iv) A Practitioner is a business partner of the Practitioner subject of the review;

(v) A Practitioner is serving as a member of the MEC and is in direct economic competition with the Practitioner under review such that an Adverse Action (as defined in the Corrective Action and Fair Hearing Plan) recommended or taken against the Practitioner (if Adverse Action is a potential immediate result of the particular review) will result (if approved by the Governing Board when such approval is required) in direct financial gain to the Practitioner;

(vi) A Practitioner is involved in a real or perceived personal conflict with the Practitioner under review.

(c) Potential conflicts of interest should be disclosed or reported to the applicable Medical Staff committee, Committee chairperson, Chief of Staff, Hospital President, and/or VPMA. Any person may raise the possibility of a potential conflict of interest. When a potential conflict of interest is raised, it is the responsibility of the applicable Committee (with whom the Practitioner is participating) to consider the matter and determine whether a potential conflict of interest exists sufficient to render the Practitioner incapable of making a determination that is reasonably based upon the pertinent circumstances and that is in the best interests of patient safety, the Medical Staff, the Hospital, and the System. If a potential conflict of interest is raised with respect to a Medical Staff Officer, Chairperson, or other Medical Staff leader in connection with a function unrelated to a particular Committee, the concern should be communicated to and addressed by the MEC.

(d) Nothing in this section, without more, is intended to preclude a Practitioner from participating in a review or other matter solely because the Practitioner practices within the same medical specialty as the Practitioner under review. Similarly, nothing in this section, without more, is intended to preclude a Practitioner from participating in a review or other matter solely because the Practitioner is employed by the System, Hospital, or an entity that is affiliated with the System or Hospital.

(e) Notwithstanding the foregoing, as set forth in the Corrective Action and Fair Hearing Manual, no Member that is in direct economic competition with an affected Member may serve on a Hearing Committee, even if such circumstance would not require removal pursuant to this section.

(f) Nothing herein precludes a Practitioner from recusing himself/herself from participating in a deliberation or vote even though a potential conflict of interest sufficient to strictly require removal pursuant to this section has not been identified.

2.7. Medical Staff Budget, Application Fees, and Dues

The Medical Staff may elect (but is not required) to maintain a budget, application fees, and/or dues. If the Medical Staff elects to do so, then the following provisions (as applicable) shall apply:

(a) A Medical Staff budget, which shall include the recommended Medical Staff application fees and annual dues, shall be prepared by the Chief of Staff or designee and approved by the MEC. Medical Staff dues may be category-specific, and may take into consideration budgetary resources and needs of each Medical Staff category. Similarly, a separate fee may be required in relation to requests for temporary Clinical Privileges (to the extent temporary Clinical Privileges are permitted as set forth herein).

(b) Applicants and Members shall be responsible for timely payment of Application Fees, Membership Dues, and/or Fines (if any) that are required by the Bylaws, Policies, and Procedures. A failure to timely pay such Fees, Dues, and/or Fines (if any and as applicable) may result in Administrative Action as set forth in the Corrective Action and Fair Hearing Manual.

(c) The Chief of Staff (or any Medical Staff Officer approved by the Chief of Staff) shall be authorized to make disbursements, on behalf of the Medical Staff that are consistent with the Medical Staff budget, any guidelines established by the MEC, that are intended to further the mission/purpose of the Medical Staff, and that are reasonably deemed to be in the best interest of the Medical Staff.

2.8. Leave of Absence

(a) A Practitioner requesting a leave of absence must submit a written request to the Hospital President, Chief of Staff, and VPMA, each by way of the Medical Staff Office. During a leave of absence, the Practitioner is not permitted to exercise Clinical Privileges at the Hospital, but retains his or her Membership on the Medical Staff, if applicable.

(b) A request for a leave of absence must state the reasons for, and the approximate duration of, the leave of absence. A leave of absence may be granted for an interval between sixty (60) days and one (1) year, and at the expiration of the first year, an additional (up to) one (1) year leave of absence may be sought; provided however, that if the requesting Practitioner's appointment to the Medical Staff or Clinical Privileges are due to expire during the course of any requested leave of absence, a leave of absence extending beyond the term of appointment shall not be granted. To extend a leave of absence beyond an existing period of appointment, a Practitioner on leave of absence must apply for and successfully receive reappointment, pursuant to the process set forth in these Medical Staff Bylaws, in conjunction with a request for an extension of the leave of absence. Failure to seek reappointment to the Medical Staff or renewal of Clinical Privileges shall result in the Practitioner's voluntary resignation from the Medical Staff and/or relinquishment of Clinical Privileges, as applicable. A Practitioner may not be granted a leave of absence beyond a total of two (2) successive years.

(c) Except as expressly provided elsewhere in this section, the Governing Board delegates to the Hospital President the authority to make final determinations in connection with requests for leaves of absence and reinstatement. In

determining whether to grant a request, the Hospital President shall consult with the Chief of Staff, VPMA, and the appropriate Clinical Department Chairperson, and shall use his or her best efforts to make a determination within thirty (30) days of the receipt of the written request based on reason(s) for request and any clarifying information requested from the Practitioner.

(d) No later than thirty (30) days prior to the termination of a leave of absence, the Practitioner may submit to the MEC a request for reinstatement of Clinical Privileges. The Practitioner must submit a written summary of relevant activities during the leave if the MEC so requested, as well as all other information reasonably requested by the MEC. The MEC, with participation of the appropriate Department Chairperson or Section Chairperson (as applicable) and in consultation (as deemed necessary) with the Credentials Committee, shall make a recommendation to the Hospital President concerning the reinstatement. The recommendation should include a plan for FPPE if the Practitioner's leave of absence was for a period greater than six (6) months and/or if determined by the MEC to be reasonably appropriate. A Practitioner shall not be reinstated, and therefore shall not be able to exercise Clinical Privileges, until the Hospital President has approved the request, even if this approval process results in a delay of reinstatement. A Practitioner who fails to submit a timely request for reinstatement shall be deemed to have voluntarily withdrawn his or her Medical Staff Membership and/or Clinical Privileges (as applicable). In such event, the Practitioner may thereafter apply as an initial Applicant.

(e) In the event the MEC's recommendation constitutes an "Adverse Action," as defined in the Corrective Action and Fair Hearing Manual, then the Practitioner shall be notified of his/her hearing rights (as applicable) pursuant to the Corrective Action and Fair Hearing Manual. Thereafter, the Governing Board shall make a final determination regarding reinstatement.

(f) In the event the MEC's recommendation does not constitute an "Adverse Action," the recommendation shall be transmitted to the Hospital President. If the Hospital President concludes that reinstatement is appropriate, then the Hospital President (or designee) will advise the Practitioner of this final determination and the effective date of the reinstatement. The Hospital President (or designee) will also advise the Practitioner of any limitations, changes in staff category, requirements, or other actions that are attendant to, or being taken with respect to, the reinstatement.

(g) In the event the Hospital President concludes, as part of his/her evaluation, that a limitation, change in staff category, requirement, or other action should be taken that would constitute an "Adverse Action," as defined in the Corrective Action and Fair Hearing Manual, then the Hospital President's determination shall be transmitted to the Governing Board in the form of a recommendation. Thereafter, the Governing Board shall evaluate the matter

and make a determination regarding the reinstatement and any associated actions.

(h) If the Governing Board concludes that "Adverse Action" is appropriate, then the Practitioner shall be notified of his/her hearing rights (as applicable) pursuant to the Corrective Action and Fair Hearing Manual. Following this process, the Governing Board shall take final action.

(i) If the Practitioner's leave of absence was for health reasons, or if health concerns are reasonably suspected or identified at the time of the requested reinstatement, the Practitioner's request for reinstatement must be accompanied by a report from the Practitioner's pertinent physician(s) or other health care provider(s) indicating that the Practitioner is physically and/or mentally capable of resuming a Hospital practice and safely executing the Membership and Clinical Privileges requested. The Hospital President, MEC, and/or Governing Board may additionally request that the Practitioner undergo physical and/or mental evaluation (at the Practitioner's cost), with the complete results of such evaluation made available to the Hospital President, MEC, and Governing Board as part of the evaluation for reinstatement.

(j) A Practitioner on a leave of absence is required to pay all Medical Staff dues and other required fees (if applicable) pursuant to Section 2.7, above, and to maintain sufficient professional liability insurance pursuant to Section 2.2.2, above.

(k) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that a Practitioner has not demonstrated good cause for a leave of absence or where a request for extension is otherwise not granted, the determination shall constitute an Administrative Action. A determination made regarding reinstatement, unless constituting an "Adverse Action" pursuant to the Corrective Action and Fair Hearing Plan, shall also constitute an Administrative Action. Further, given the evaluation and meetings that may be necessary in order to fully evaluate a requested return from Leave of Absence, nothing here requires the Medical Staff and/or Governing Board to complete their evaluation, and arrive at a final determination, within thirty (30) days of the Practitioner's request. Rather, the Medical Staff and Governing Board, as applicable, shall consider the matter in a reasonably prompt manner.

2.9. Medical Staff Year

The Medical Staff Year is from January 1 to December 31.

ARTICLE III

CATEGORIES OF THE MEDICAL STAFF

3.1. The Medical Staff

The Medical Staff shall be organized into the categories set forth below. All Members of the Medical Staff, except for Members of the Honorary Staff, must satisfy the basic qualifications and responsibilities as applicable and set forth in Sections 2.2 and 2.3 of this Manual. Members must also satisfy such other qualifications that are specific to each category. All initial Medical Staff category placements shall be provisional in nature, as set forth below. Based upon the qualifications for each category, Members may be administratively reclassified to the category for which they are eligible should the Member's status or eligibility change during an appointment period and/or as a result of amendment(s) to these Medical Staff Bylaws, which effectively require such reclassification.

3.2. The Active Staff

The Active Staff is generally responsible to the Governing Board for the quality of medical care and treatment of inpatients and outpatients in the Hospital and the overall organization of the Medical Staff. Members of the Active Staff are expected to contribute to the organizational and administrative affairs of the Medical Staff.

3.2.1. Qualifications

The Active Staff shall consist of Physicians, Dentists, Oral Surgeons, and Podiatrists appointed to a specific Medical Staff Department, who meet the following requirements in the discretion of the Governing Board upon recommendation from the MEC:

(a) Are professionally based in, or otherwise regularly available to, the communities served by the Hospital;

(b) Regularly admit, attend to, and/or treat patients at the Hospital within their scope of practice and granted Clinical Privileges, or alternatively, are not clinically active in the inpatient setting, but maintain an active ambulatory practice in one or more communities served by the Hospital and are actively involved in Hospital and Medical Staff activities. Consistent with the foregoing, and as part of the Hospital's effort to sustain medical excellence, members of the Active Staff are expected to maintain at least thirty-six (36) Contacts per three (3) year period of appointment (or pro rata percentage if the period of appointment is less than three years) in order to remain eligible for reappointment to the Active Staff. Notwithstanding the foregoing, the Governing Board, following recommendation from the MEC, may make an exception to this Contact requirement for good cause when the Practitioner is able to otherwise document the Practitioner's regular efforts to support the Hospital's patient care mission; and

(c) As an alternative to the preceding subsections (a) through (b), Active Staff status may also be extended to those Physicians, Dentists, Oral Surgeons, and Podiatrists who otherwise meet the basic eligibility requirements for Membership and Clinical Privileges, set forth above, and hold a Medical-Administrative position at the Hospital, the System, or at another healthcare entity directly affiliated with System, whether or not such individuals also maintain Clinical Privileges while holding such position.

3.2.2. Responsibilities

Members of the Active Staff shall:

(a) Regularly attend and participate in meetings of the Department to which the Member is appointed;

(b) Meet established continuing medical education requirements;

(c) Actively participate in quality assessment and improvement activities of the Medical Staff, and participate on Department and Medical Staff committees when requested;

(d) Pay Medical Staff dues, fees, and fines (if applicable);

(e) Provide emergency service specialty call coverage (including appropriate out-patient follow-up to patients who are seen in the Emergency Department as may be required by pertinent Law), as well as call coverage for unattached patients, to the extent permitted by law and regulation, and in a manner consistent with the Practitioner's licensure, scope of practice, and Clinical Privileges;

(f) Maintain accurate, legible, timely and complete medical records; and

(g) Demonstrate the capability to provide continuous and timely patient care to the satisfaction of the MEC and Governing Board.

3.2.3. Prerogatives

Members of the Active Staff may:

(a) Exercise such Clinical Privileges as are granted by the Governing Board; these Clinical Privileges may include permission to admit patients to the Hospital;

(b) Participate in Hospital and Medical Staff educational opportunities;

(c) Serve on Department and Medical Staff committees;

(d) Vote on all matters presented at general and special meetings of the Medical Staff and the Department and Medical Staff committees of which they are a Member; and

(e) Hold Office at any level of the Medical Staff organization.

3.3. The Associate Staff

The Associate Staff shall consist of Physicians, Dentists, Oral Surgeons, and Podiatrists who intend to maintain and exercise Clinical Privileges in-person at the Hospital, but who do not meet the qualifications for the Active Staff category.

3.3.1. Qualifications

The Associate Staff shall consist of Physicians, Dentists, Oral Surgeons, and Podiatrists appointed to a specific Medical Staff Department, who meet the following requirements in the discretion of the Governing Board upon recommendation from the MEC:

(a) Are professionally based in, or otherwise regularly available to, the communities served by the Hospital; and

(b) Demonstrate in-person clinical activity at the Hospital, but have fewer than thirty-six (36) Contacts per appointment period and/or do not meet one or more other requirements for the Active Staff.

3.3.2. Responsibilities

Members of the Associate Staff shall:

(a) Make reasonable attempts to attend and participate in meetings of the Medical Staff;

(b) Maintain a sufficient level of activity at the Hospital to comply with the Medical Staff's Policy for Ongoing Professional Practice Evaluation;

(c) Meet established continuing medical education requirements;

(d) Actively participate in quality assessment and improvement activities of the Medical Staff;

(e) Pay Medical Staff dues, fees, and fines (if applicable);

(f) Unless exempted by the MEC or Governing Board, provide emergency service specialty call coverage, as well as call coverage for unattached patients, to the extent permitted by law and regulation, and in a manner consistent with the Practitioner's licensure, scope of practice, and Clinical Privileges;

(g) Maintain accurate, timely and complete medical records; and

(h) Demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and Governing Board.

3.3.3. Prerogatives

Members of the Associate Staff have the same prerogatives as Members of the Active Staff, except that Members of the Associate Staff may not serve as a Department Chairperson, may not hold office at any level of the Medical Staff organization and may attend, but not vote at, Departmental or Section meetings, or general or special meetings of the Medical Staff. Except with respect to service on the MEC, Members of the Associate Staff may serve on Medical Staff committees, with or without vote in the discretion of the Medical Staff committee chairperson, if requested by the MEC or Medical Staff committee chairperson to serve on such committee.

3.4. The Beacon Staff

The Beacon Staff shall consist of Physicians, Dentists, Oral Surgeons, and Podiatrists who maintain a primary practice location and Active Staff membership at another Beacon hospital and who meet the requirements set forth below. For clarity, nothing herein requires an applicant or reapplicant to apply to the Beacon Staff category. Such applicants and reapplicants are permitted to apply for participation in other Medical Staff categories if they meet the qualifications for same, but in such event shall be subject to all attendant responsibilities of that category.

3.4.1. Qualifications

Members of the Beacon Staff shall consist of those Physicians, Dentists, Oral Surgeons, and Podiatrists appointed to a specific Medical Staff Department, who meet the following requirements in the discretion of the Governing Board upon recommendation from the MEC:

(a) Maintain Active Staff Category membership and clinical privileges (with associated on-call obligations), in good standing, at another Beacon Health System hospital (i.e., other than the Hospital where Beacon Staff Category participation is sought), which is referred to in this section as the Practitioner's "Primary Practice Location";

(b) In the discretion of the MEC, do not exceed the Practitioner's average number of Contacts, on an annual basis, at the Practitioner's Primary Practice Location; and

(c) Desire, for purposes of appropriate clinical coverage and/or continuity of patient care within the System, to exercise Clinical Privileges at the Hospital.

3.4.2. Responsibilities

Members of the Beacon Staff shall:

(a) Contribute to the organization and administrative affairs of the Medical Staff as may be requested.

(b) Actively participate as requested or required in the activities and functions of the Medical Staff, including Committee membership, quality/performance improvement, credentialing, risk management, utilization management, medical records completion, other peer review activities, and the discharge of Medical Staff functions as required.

(c) Be exempt from Emergency Department call coverage obligations, unless the Hospital, in consultation with the Medical Executive Committee, determines in its discretion that such call coverage is either: (a) required by a professional services arrangement applicable to the Member or (b) is otherwise required in order to ensure Hospital's compliance with legal and/or accreditation requirements, including but not limited to EMTALA.

(d) Comply with all applicable Medical Staff or Hospital Bylaws, Rules, Regulations, Policies and Procedures, and pay all Medical Staff assessments when due.

3.4.3. Prerogatives

Members of the Beacon Staff may:

(a) Exercise Clinical Privileges at the Hospital subject to the limitation set forth in Section 3.4.4, below.

(b) If requested by the MEC, serve on any Medical Staff Committee(s) (other than the MEC) with vote.

(c) Attend general Medical Staff meetings (without vote) and attend meetings of the Department to which they are assigned (without vote).

(d) Not serve as a Medical Staff Officer, Department Chief, Department Vice-Chief, or Chair of any Committee.

3.4.4. Beacon Staff Clinical Privileges

Members of the Beacon Staff may apply and/or reapply (as applicable) for Beacon Staff Clinical Privileges at the Hospital. Beacon Staff Clinical Privileges, if granted, permit such Member to exercise Clinical Privileges within the Member's licensed scope of practice, subject to the Hospital's applicable and approved Clinical Privileging form, except that such Members shall not be extended admitting privileges at the Hospital.

3.5. The APP Staff

The APP Staff shall consist of those Advanced Practice Professionals who are authorized by the Governing Board to exercise specified Clinical Privileges within the Hospital. APPs who seek Membership on the Medical Staff, and either intend to (a) exercise all clinical privileges (i.e. – their entire clinical practice at the Hospital) remotely via telemedicine link (if the MEC and Hospital have approved such practice) or (b) are professionally based in the community served by the Hospital, but do not intend to maintain any Clinical Privileges other than "refer

and follow" Clinical Privileges may qualify for the Affiliate Staff, as set forth in Section 3.6, below. APPs who do not meet the criteria/requirements for Membership may nevertheless qualify for Clinical Privileges if determined to be eligible pursuant to the Bylaws, Policies, and Procedures.

3.5.1. Qualifications

Members of the APP Staff shall be appointed to a specific Medical Staff Department and shall meet the following requirements in the discretion of the Governing Board upon recommendation from the MEC:

(a) Are professionally based in, or otherwise regularly available to, the communities served by the Hospital; and

(b) Regularly care for, treat, and/or render professional health care services to patients at the Hospital within their scope of practice and granted Clinical Privileges, or alternatively, are not clinically active in the inpatient setting, but maintain or participate in an active ambulatory practice in one or more communities served by the Hospital and are actively involved in Hospital and Medical Staff activities. Consistent with the foregoing, and as part of the Hospital's effort to sustain medical excellence, members of the APP Staff are expected to maintain at least thirty-six (36) Contacts per three (3) year period of appointment (or pro rata percentage if the period of appointment is less than three years) in order to remain eligible for reappointment to the APP Staff.

3.5.2. Responsibilities

Members of the APP Staff shall:

(a) Regularly attend and participate in meetings of the Department to which the Member is appointed;

(b) Satisfy any patient contact requirements established by the applicable Department in order to evaluate ongoing quality and competency as a prerequisite to obtaining and maintaining Clinical Privileges;

(c) Actively participate in FPPE to establish competency in relation to the Clinical Privileges that are requested, or as otherwise requested;

(d) Meet established continuing medical education requirements;

(e) Actively participate in quality assessment and improvement activities of the Medical Staff, and participate on Department and Medical Staff committees when requested;

(f) Pay Medical Staff dues, fees, and fines (if applicable);

(g) Maintain accurate, legible, timely and complete medical records; and

(h) Demonstrate the capability to provide continuous and timely patient care to the satisfaction of the MEC and Governing Board.

3.5.3. Prerogatives

Members of the APP Staff may:

(a) Exercise such Clinical Privileges as are granted by the Governing Board subject to all applicable requirements/limitations attendant to APPs;

(b) Participate in Hospital and Medical Staff educational opportunities;

(c) Serve on Department and Medical Staff committees if requested and to the extent permitted by the Bylaws, Policies, and Procedures;

(d) Attend (without vote) general and special meetings of the Medical Staff and the Department to which they are assigned;

(e) Members of the APP Staff may not serve as a Department Chairperson, Section Chairperson, Chairperson of a Medical Staff committee, and may not hold office at any level of the Medical Staff organization.

3.6. The Affiliate Staff

The Affiliate Staff shall consist of Physicians, Dentists, Oral Surgeons, and APPs who seek Membership on the Medical Staff, and either intend to (a) exercise all clinical privileges (i.e. – their entire clinical practice at the Hospital) remotely via telemedicine link (if the MEC and Hospital have approved such practice) or (b) are professionally based in the community served by the Hospital, but do not intend to maintain any Clinical Privileges other than “refer and follow” Clinical Privileges. Members who otherwise qualify for the Active Staff or Associate Staff, but who maintain only “refer and follow” Clinical Privileges at the Hospital, may opt to be part of the Affiliate Staff.

3.6.1. Qualifications

The Affiliate Staff shall satisfy the qualifications set forth in Sections 2.2 and 2.3.

3.6.2. Responsibilities

Members of the Affiliate Staff shall, as applicable:

(a) Meet established continuing medical education requirements;

(b) Actively participate in quality assessment and improvement activities of the Medical Staff;

(c) Pay Medical Staff dues, assessments, and fines; and

(d) Maintain accurate, timely and complete medical records.

3.6.3. Prerogatives

Members of the Affiliate Staff may attend Medical Staff and Department meetings, and may exercise such Clinical Privileges as are granted by the Governing Board, provided however that Affiliate Staff are not eligible for admitting privileges and may not serve as the primary or principal Physician who provides treatment of any Hospital patient. Affiliate Staff Members shall not be eligible to serve on Medical Staff committees, vote, or hold elected office in the Medical Staff.

3.7. The Honorary Staff

3.7.1. Qualifications

The Honorary Staff are those Physicians, Dentists, Oral Surgeons, Podiatrists, and APPs who are recognized for their noteworthy contributions to the community, Medical Staff and Hospital. Honorary Staff Members must have served on the Medical Staff no fewer than ten (10) years, and who have retired from the active practice of medicine. The Honorary Staff is restricted to those Members recommended by the MEC and approved by the Governing Board. Honorary Staff are not required to satisfy the qualifications or responsibilities set forth in Sections 2.2 and 2.3 herein.

3.7.2. Responsibilities

Members of the Honorary Staff have no responsibilities to the Medical Staff, provided however, that Honorary Staff participating in Medical Staff activities must do so in a constructive manner and not otherwise violate applicable codes of conduct or related policies.

3.7.3. Prerogatives

(a) Members of the Honorary Staff may attend any meeting of the Medical Staff or Department to which he or she was formerly appointed or would be appointed if the Member was active in the Hospital, unless otherwise excluded for good cause by Medical Staff or Department leadership. Honorary Staff may also participate in Hospital and Medical Staff educational opportunities;

(b) Honorary Staff Members shall not be eligible to vote at general or special Medical Staff, Department, Committee meetings or hold elected office in the Medical Staff and may not serve on Medical Staff committees, unless by special invitation of the MEC; and

(c) Honorary Medical Staff Members are not eligible for Clinical Privileges.

3.8. Provisional Status

Provisional status is not a staff category. Rather, it is a status applicable to all initial appointments of Practitioners to the Active Staff, Associate Staff, APP Staff, and Affiliate Staff. All initial appointments shall be provisional in nature (based upon MEC's recommendation for staff category placement as approved by the Governing Board) for a period of one (1) year, unless this period is extended by the MEC. During the provisional period, and unless the MEC elects to make an exception for good cause (which shall be subject to approval by the Governing Board), these Members may undertake any prerogative consistent with their assigned Category, but are not eligible to serve as a Medical Staff Officer or as a member of the MEC. The restrictions attendant to Provisional Status, as set forth above, are in addition to any requirements/limitations of the applicable Medical Staff Category. Nothing in this Section is intended to expand the rights of such Members. Following the provisional period, Members may be administratively reclassified to a different category, based upon MEC recommendation, in the event the MEC determines the Practitioner's performance and/or qualifications to date is/are inconsistent with the requirements for the originally assigned Medical Staff category. Any such reclassification shall be considered an Administrative Action.

3.8.1. Observation during Provisional Period/FPPE

Members subject to provisional status (as well as current Members of the Medical Staff requesting new or additional Clinical Privileges) shall undergo a period of Focused Professional Practice Evaluation in order evaluate the Member for (1) proficiency in the exercise of Clinical Privileges initially granted and (2) overall eligibility for continued staff Membership in the assigned category. The extent, nature and duration of the period of FPPE, or any extension of such FPPE, shall be determined by the MEC, in consultation with the pertinent Clinical Department Chairperson, and in accordance with the Hospital's policy for FPPE. For clarity, nothing herein requires that the period applicable FPPE be of the same duration as Provisional Status.

3.8.2. Action at Conclusion of Provisional Status

If following the period of provisional status, the Member has satisfactorily demonstrated (1) his or her ability to exercise the Clinical Privileges initially granted, and (2) qualification for continued Medical Staff Membership in the assigned category, then upon recommendation by the MEC, with approval of the Governing Board, the period of provisional status shall terminate. In all other cases, the MEC shall determine, following consultation with the pertinent Department Chairperson (or designee), whether the period of provisional status should be extended and/or whether some other action should be considered, as permitted by these Medical Staff Bylaws.

3.9. Orientation

Each Member subject to provisional status may additionally be required to participate in a Medical Staff orientation program that is approved by the MEC. Orientation may include, among other topics/curriculum, Hospital or System sponsored training programs, including but not limited to those related to electronic medical record (EMR) implementation and use.

Failure to attend and/or meaningfully participate in and complete an orientation program, if implemented by the MEC, may result in Administrative Action up to and including the automatic suspension and revocation of a provisional Member's Medical Staff Membership and Clinical Privileges.

ARTICLE IV

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT OF MEMBERSHIP AND/OR CLINICAL PRIVILEGES

4.1. Pre-Application Procedures

4.1.1. Form Preparation

The Credentials Committee, with the assistance of the Hospital's Medical Staff Office, shall be responsible for developing, reviewing, and recommending any changes to application forms, including any application request form that may be utilized, appointment, reappointment, and updating forms. All forms and revisions thereto shall be reviewed and approved by the MEC and the Governing Board, and shall conform to any applicable Indiana state statutes and regulations that mandate the use of particular forms or specific content.

4.1.2. Request for Application

(a) Any individual seeking Medical Staff Membership and/or Clinical Privileges must request in writing an application from Medical Staff Office or (if applicable) the Hospital's designated Credentialing Verification Organization ("CVO"). The request should be accompanied by a copy of his or her current curriculum vitae and any additional or supporting information that may be requested or required as part of the pre-application process.

(b) Pre-applicants may be administratively denied an application if it is apparent that the pre-applicant does not meet the basic eligibility requirements for Medical Staff Membership and/or Clinical Privileges, as applicable. Any pre-applicant denied an application shall receive a written response to his or her request explaining the general reason(s) for the administrative denial, including any reason(s) based in whole or in part on the pre-applicant's qualifications or any other basis, including exclusive or closed services or Clinical Privileges, or other economic factors and/or need determinations. Any such administrative denial constitutes an Administrative Action. Otherwise, the pre-applicant shall be provided an application. Receipt of an application does not, however, preclude a subsequent finding of administrative ineligibility or otherwise in any fashion guarantee that Medical Staff Membership and/or Clinical Privileges, as applicable, will be granted.

4.2. Application for Initial Appointment and/or Clinical Privileges

4.2.1. Application Form

Each application for appointment to the Medical Staff and/or Clinical Privileges, as applicable, shall be in writing, submitted on the prescribed form, and signed by the pre-applicant. Electronic submission of such forms, as directed by the Medical Staff Office, shall be acceptable. Once a signed and completed application form has been received and accepted by Medical Staff Office (or the Hospital's CVO if such function is delegated to a designated CVO), the pre-applicant shall be considered an Applicant.

4.2.2. Content

The Hospital's form of application includes, at a minimum, the following requests for information. The Hospital may supplement its application form content by general or specific requests for information.

(a) Acknowledgment and Agreement. A statement that the Applicant has received or has had access to the Bylaws, Policies, and Procedures, has read and understands the Bylaws, Policies, and Procedures (or has otherwise elected to his/her potential detriment not read/review the Bylaws, Policies, and Procedures), and agrees to be bound by the Bylaws, Policies, and Procedures, including but not limited to all applicable provisions in all matters relating to consideration of his or her request for initial or continuing Medical Staff Membership and/or Clinical Privileges.

(b) Qualifications and Professional History. Detailed information concerning the Applicant's qualifications, demonstrated current competency and professional performance, including information regarding the qualifications specified in the Medical Staff Governance and Credentialing Manual and of any additional qualifications established by the Medical Staff or Governing Board for the particular Medical Staff category, Department, and/or Clinical Privileges being requested. Additionally, any faculty membership at any medical or other professional school; names and locations of past or current professional employment; and names and locations of any other past or current hospitals or other licensed health facilities where the Applicant has applied or received medical staff membership and/or clinical privileges.

(c) Requests. A request stating the Medical Staff category, Department, Section (if applicable), and Clinical Privileges for which the Applicant desires to be considered.

(d) References. The names of at least two (2) professional peers who have personal knowledge of Applicant's/Member's current clinical skills, abilities, character, ethics, judgment, professional performance, and clinical competence or have otherwise been responsible for professional observation of Applicant's/Member's professional services. For purposes of this section, a “peer” is defined as an individual in the same professional discipline as the

Applicant. (MD and DO are considered equivalent). A “peer” does not include a residency director, fellowship director, or personal relative. At least one peer reference should be an individual that is within the same specialty as Applicant. For purposes of this section, a Physician (with at least equivalent Clinical Privileges as an Applicant/Member who is a Nurse Practitioner or Physician Assistant) shall be considered to be within the same discipline and specialty as the Nurse Practitioner or Physician Assistant. With respect to new physician graduates, at least one (1) (of the two) professional references must be a Residency or Fellowship Program Director.

(e) Professional Sanctions. Information regarding whether any of the following have ever been or are in the process of being denied, revoked, suspended, reduced, restricted, probationary, not renewed, or voluntarily relinquished or voluntarily not exercised shall be reported in detail:

(i) Medical Staff Membership status and/or Clinical Privileges at any other hospital or health care facility;

(ii) Membership/Fellowship in local, state or national professional organizations;

(iii) Board Certification or related Board Certification status;

(iv) License to practice any profession in any jurisdiction; and

(v) Any state Controlled Substance License or Drug Enforcement Administration Controlled Substances Registration Certificate (DEA).

(f) Additional Disclosures.

The Applicant shall disclose:

(i) Any and all malpractice suits, settlements and judgments to which he or she is or has been a party during the past ten (10) years;

(ii) Any remedial, corrective or disciplinary action of any kind taken by any hospital, Medical Staff, professional organization, licensing body or governmental agency;

(iii) Any circumstance where employment, Medical Staff membership and/or clinical privileges were reduced, suspended, diminished, revoked, refused, voluntarily not exercised, or limited at any hospital or other health care facility, whether voluntarily or involuntarily;

(iv) Any circumstance where he or she withdrew an application for appointment/reappointment and/or clinical privileges, or resigned from a medical staff or clinical privileges to avoid an investigation

before action by a hospital's or health facility's medical staff or governing board;

(v) Any past or current investigations due to inappropriate conduct, disruptive behavior, or unprofessional conduct (e.g., sexual harassment);

(vi) Any past or current investigations, focused individual monitoring, review, or audits related to the quality of care or competency;

(vii) All other information residing in the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank;

(viii) All healthcare related employment/appointments (work history);

(ix) All information related to the investigation, arrest, indictment or conviction with regard to any felony or misdemeanor;

(x) Current criminal background check;

(xi) All information as to the Applicant's medical education and post-medical school training; and

(xii) Any information requested on the supplemental form utilized as part of the Medical Staff Membership and/or Clinical Privileges application process.

(g) Notification of Release of Immunity Provisions. Statement notifying the Applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions contemplated by these Medical Staff Bylaws.

(h) Administrative Remedies. A statement that the Applicant agrees that if an adverse decision is made with respect to his or her Medical Staff Membership status and/or Clinical Privileges, the Applicant will exhaust or waive any administrative remedies afforded by the Medical Staff Bylaws prior to initiating any purported request for judicial review or other legal action (notwithstanding any other legal and/or factual deficiency in such action).

(i) Financial Responsibility. Evidence that the Applicant has secured or currently maintains professional liability insurance in a form and in such amounts as prescribed by the Governing Board.

(j) Obligation to Update. The application form includes a statement that the Applicant acknowledges that he or she has the burden of providing any and all information necessary to process the application as determined in the discretion of the Credentials Committee, MEC, or Governing Board; that he or she is solely responsible for supplementing his or her application during the application process, in addition to the disclosure requirements set forth in

these Medical Staff Bylaws, to ensure the absolute accuracy of all statements and information contained therein as soon as this information becomes known but, in any event, before a final appointment or reappointment decision is made; and that any false or misleading information provided by a pre-applicant, Applicant, Member, or Practitioner during the pre-application, application, appointment, reappointment, or renewal process may be treated as a voluntary relinquishment or otherwise serve as grounds for Administrative Action, corrective action, and/or termination of the credentialing process, as applicable.

(k) Consent and Authorization to Share Information. As a condition of Membership and/or Clinical Privileges, the Applicant agrees that any quality, Peer Review, and other related information that is collected as part of the appointment/reappointment or privileging process, as well as any other Peer Review activities, may be shared with other health care organizations and entities and their designees, including without limitation those that are administratively and clinically affiliated with the Hospital and Applicant for purposes related to credentialing, privileging, managed care participation or any other System quality review or service line activities, and any other health care facility or organizations at or for which the Applicant seeks to practice.

4.3. Effect of Application

By applying for Membership and/or Clinical Privileges, and in addition to any other conditions, commitments or releases contained throughout the Bylaws, Policies, and Procedures, each Applicant:

(a) Attests to the accuracy and completeness of all information on his or her application or accompanying documents and agreement that any inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process, which is an Administrative Action. Each Applicant further acknowledges that if a material inaccuracy, omission or misstatement is discovered after an individual has been granted appointment and/or Clinical Privileges, the individual's appointment and Clinical Privileges shall lapse effective immediately upon notification of the individual. All determinations regarding whether an accuracy, omission or misrepresentation is material in nature shall be made by the MEC in its sole discretion, and shall constitute an Administrative Action;

(b) Signifies willingness to appear for interviews in regard to his or her application;

(c) Authorizes Hospital and Medical Staff representatives to consult with others who have been associated with him/her and/or who may have information bearing on the Applicant's competence and qualifications;

(d) Consents to Hospital and Medical Staff representatives inspecting all records and documents that may be material to an evaluation of professional

qualifications and competence to carry out the Clinical Privileges requested, of physical and mental health status and of professional ethical qualifications;

(e) Releases from liability, extends absolute immunity to, and agrees not to sue the System, the Hospital, the Hospital's agents, the Governing Board, the Medical Staff, any Member of the Medical Staff, and any Medical Staff committee for their Peer Review activities, including the evaluation of the applicant, any determinations made or actions taken with respect to the applicant, and any use or communication of privileged or confidential information concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Medical Staff appointment and Clinical Privileges (as applicable);

(f) Releases from any liability, extends absolute immunity to and agrees not to sue any individuals or organizations who provide information in good faith to Hospital and Medical Staff representatives concerning the Applicant's competence, professional ethics, character, physical and mental health, emotional stability and other qualifications for Medical Staff appointment and Clinical Privileges;

(g) Authorizes the System, Hospital and Medical Staff, and their designees to provide other hospitals, medical associations, the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank, licensing boards, affiliated entities of System (or its successor), other health care facilities or organizations of health professionals with any information relevant to such matters that the Hospital may have concerning him or her, and releases Hospital and Medical Staff representatives from liability for so doing; and

(h) In addition to the preceding paragraph (g), acknowledges and agrees to the Hospital's policies and procedures for appropriately sharing information, including but not limited to Peer Review information, with other affiliated entities and with third parties who are permitted to receive such information; each Applicant/Member hereby agrees: (a) to execute and comply with any Authorization and Release documents that may be requested by the Hospital and/or Medical Staff to facilitate the sharing of such information, and (b) that such information, when shared or exchanged, may be evaluated and utilized as part of the appointment/reappointment or privileging process, may form the basis for a request for corrective action and/or an adverse action, and may also be exchanged as part of the preliminary review and/or investigation processes set forth in the Medical Staff Bylaws.

4.4. Processing the Application

All requests for Medical Staff Membership and/or Clinical Privileges by Physicians, Dentists, Oral Surgeons, Podiatrists, and APPs, as applicable, will be processed pursuant to the procedures set forth in these Medical Staff Bylaws. All requests for permission to provide patient care services by AHPs will be processed and evaluated by the Hospital through its

Human Resources Department in a manner consistent with the Hospital's pertinent policies and procedures. The Hospital may additionally delegate, in its discretion, certain credentialing verification functions pertinent to AHPs to a CVO.

4.4.1. Applicant's Burden

The Applicant shall have the burden to produce adequate information for a proper evaluation of the Applicant's licensure status, experience, education, background, training, current competence, demonstrated ability, physical and mental health status, emotional stability, character, and judgment, and of resolving any doubts about these or any of the other basic qualifications specified or referenced throughout the Medical Staff Bylaws. All information required to be provided or disclosed, including supplemental requests by the applicable Department, Credentials Committee, MEC or Governing Board, must be submitted within thirty (30) days of the request or within the timeframe otherwise specified by the requesting party or otherwise set forth in the Bylaws, Policies, and Procedures. If an applicant fails to meet this burden, the application will be deemed withdrawn and closed. Unless waived by the MEC or Governing Board for good cause, the Applicant will not be eligible to submit a new application for a period of one (1) year from the date the initial application was deemed to be withdrawn.

4.4.2. Verification of Information/Complete Application.

(a) The Applicant shall return an application that contains all requested information to the System Medical Staff Office or a designated CVO within sixty (60) days from the date the application was initially mailed, or otherwise provided to, the Applicant. Otherwise, the application shall be deemed automatically withdrawn.

(b) The Hospital and Medical Staff representatives, in conjunction with the CVO (if applicable), shall in timely fashion seek to collect and obtain primary source verification of the Applicant's licensure history, medical education and postgraduate training, malpractice insurance history, board certification status, sanctions and disciplinary actions, criminal history, employment/appointment history, professional references, and other qualification evidence submitted, including, but not limited to, a query of the National Practitioner Data Bank, AMA and AOA (as applicable), the Office of the Inspector General, and Medicare/Medicaid Exclusion list. The Hospital and Medical Staff representatives, in conjunction with the CVO (if applicable), will also request from the Indiana Division of Professional Regulation all information concerning the licensure status and any disciplinary action taken against an Applicant's license.

(c) An Applicant shall be notified of any problems or omissions in obtaining the information required, and it shall then be the Applicant's obligation to obtain or provide the required information.

(d) Once all requested information has been received and verified, the application shall be deemed complete. The application and all supporting information and documentation (referred to herein as a "Complete Application") shall then be forwarded to the applicable Department or Section Chairperson. In the event the Credentials Committee, MEC, or Governing Board (or their respective designees) thereafter determine at any point that any additional documentation or information is necessary to fully evaluate the application, the Applicant shall have the burden to timely provide (or cause to be provided) such documentation/information. The application shall be deemed incomplete upon such a determination/request and until such time as the Applicant has timely provided all requested documentation and information. Incomplete applications may be deemed withdrawn and closed as set forth above in Section 4.4.1. Any such closure shall constitute an Administrative Action.

(e) Upon receipt of the Complete Application, the Medical Staff Office shall transmit the application and all other supporting materials to the Chairperson of each Department in which the applicant requests Clinical Privileges, or alternatively, to the Chairperson of each Section in which the Applicant requests Clinical Privileges (if applicable). Any additional information and materials received will also thereafter be transmitted to the Department Chairperson(s) and/or Section Chairperson (as applicable).

4.4.3. Department/Section Action

The Department Chairperson, with the additional review and recommendation of the Section Chairperson (if applicable), shall initially review the application and all supporting materials furnished by the Applicant. The Department Chairperson (and/or Section Chairperson, if applicable) has the discretion to call a meeting with the Credentials Committee or other Members of the Department (or Section, if applicable) to assist the Chairperson (or Section Chairperson, if applicable) in the credentialing and privileging process, and has the discretion to conduct an interview with, or otherwise request additional information from, the Applicant. As soon as practicable, but not more than thirty (30) days after receiving the application unless circumstances reasonably require additional time, the Chairperson shall transmit a written recommendation, including delineated Clinical Privileges, to the Credentials Committee. The Chairperson's written recommendation should include a statement that the requested appointment and/or Clinical Privileges be granted, denied, or modified, and should also contain the recommendation of the Section Chairperson (if applicable), as well as reference to any additional information that is deemed relevant to the review. The Department Chairperson (and Section Chairperson, if applicable) shall conduct his or her review on behalf of the applicable Departmental Committee (or Section Committee, if applicable), which shall function as a Peer Review Committee.

4.4.4. Credentials Committee Recommendation

(a) Within thirty (30) days after receiving the application, the supporting materials and the written recommendation from the Chairperson of the Department (and Section Chairperson, if applicable), and unless additional time is reasonably required in the discretion of the Credentials Committee Chairperson, the Credentials Committee shall review the application, all supporting materials, the Chairperson's (and Section Chairperson's, if applicable) recommendation, and shall conduct any further investigation of the Applicant as determined to be warranted. The Credentials Committee may additionally (but is not required to) conduct a personal interview (directly or through a Credentials Committee representative) with the Applicant if it deems an interview is appropriate.

(b) Once the Credentials Committee has considered the licensure status, training/education, professional competence, character, judgment, experience, health status, ethical standing of the Applicant and other applicable qualifications of the Applicant, it shall transmit its recommendation to the MEC. If appointment to the Medical Staff and/or Clinical Privileges is recommended, and provided all other conditions of appointment are satisfied, the recommendation shall state the Medical Staff Category, Department affiliation, and Section affiliation (if applicable), as well as any special condition(s) to be attached to the appointment. The Credentials Committee may also recommend that the MEC defer action on the application, stating the reason for such recommendation.

(c) The Credentials Committee shall conduct its review as a Peer Review Committee, and shall do so with the intent of reducing morbidity and mortality and improving the quality of patient care provided at the Hospital.

4.4.5. Medical Executive Committee Action

The MEC, at its next regular meeting or at such other appropriate time after receipt of the written report and recommendations of the Credentials Committee, shall consider those reports and all other relevant information available to it or otherwise requested. The MEC shall then determine whether to:

(a) Recommend to the Governing Board that the Applicant be appointed to the Medical Staff and/or that specific Clinical Privileges be granted;

(b) Recommend to the Governing Board that some or all elements of the Medical Staff Membership and/or Clinical Privileges sought by the Applicant be restricted and/or denied; and/or

(c) Defer MEC action on the application for no more than sixty (60) days, unless circumstances reasonably require additional time, at which time a recommendation to the Governing Board/Hospital President must be made.

If the MEC's recommendation includes or constitutes an "Adverse Action" (as set forth in the Corrective Action and Fair Hearing Manual), the Hospital President (or designee) shall send a Special Notice of Adverse Action to the Applicant, and the Applicant shall be afforded hearing and appeal rights as set forth in the Corrective Action and Fair Hearing Manual before the MEC's final recommendation is transmitted to the Board. A copy of the Special Notice shall be provided to the Hospital President and Chief of Staff.

The Chief of Staff, or his/her designee, shall thereafter present the MEC's recommendation for Medical Staff Membership and/or Clinical Privileges (as applicable) to the Governing Board for its consideration. The recommendation shall state the Medical Staff category, Department affiliation, Section affiliation (if applicable), and any special condition(s) to be attached to the appointment.

The MEC shall conduct its review as a Peer Review Committee, and shall do so with the intent of reducing morbidity and mortality, and to improve the quality of patient care provided at the Hospital.

4.4.6. Governing Board Action

Upon reviewing the application and all supporting material forwarded by the MEC, at its next regular meeting, the Governing Board shall, in whole or in part, accept or decline to accept the recommendation of the MEC. Alternatively, it may refer the application back to the MEC for further consideration, stating the reasons for this action and setting a time limit within which any subsequent recommendation shall be made.

Whenever the Governing Board's decision is contrary to or materially different from the MEC's final recommendation, the Governing Board shall notify the MEC. In such circumstances, if the MEC or the Governing Board so request, the Governing Board shall first submit the matter to a Joint Conference Committee which shall report its recommendation to the Governing Board within fourteen (14) days of the action proposed by the Governing Board, unless additional time is reasonably required. Under such circumstances, the Governing Board shall consider the report of the Joint Conference Committee and then take its final action. The Governing Board is responsible for the final decision, based on Medical Staff recommendations, regarding an individual's Medical Staff Membership and/or the grant of Clinical Privileges (as applicable). In rendering its final decision regarding a Complete Application, the Governing Board shall recognize the primary role of the Medical Staff in reviewing the qualifications of Medical Staff Applicants. The Governing Board's determinations with respect to such recommendations shall be based on the information and recommendations submitted by the Medical Staff, and other relevant information, provided, however, that the recommendations of the Medical Staff shall be given appropriate weight and authority given its expertise in these areas; and provided further that while the Governing Board has the ultimate authority with respect to such decisions, the Governing Board shall conduct its review and reach a final determination as a Peer Review committee and shall do so with the intent of reducing

morbidity and mortality and improving the quality of patient care provided at the Hospital.

4.4.7. Notice of Final Decision

(a) If the Governing Board's action is favorable to the Applicant, it shall become effective as a final determination. Notice of final determinations shall be communicated to the Chief of Staff, the Chairperson of each Department/Section concerned, and the Medical Staff Office, who shall promptly notify the Applicant in writing. The written notice should include, as applicable, the Medical Staff category to which the Applicant is appointed, the Department and Section (as applicable) to which he or she is assigned, the Clinical Privileges he or she may exercise, and any special condition(s) attached to the Membership and/or Clinical Privileges.

(b) If the decision of the Governing Board independently constitutes an "Adverse Action" (as set forth in the Corrective Action and Fair Hearing Manual), the Hospital President (or designee) shall send a Special Notice of Adverse Action to the Applicant, and the Applicant shall be afforded hearing and appeal rights as set forth in the Corrective Action and Fair Hearing Manual. A copy of the Special Notice shall be provided to the Hospital President and Chief of Staff.

4.4.8. Reapplication After Adverse Appointment of Privileges Decision

An Applicant who has received a final adverse decision regarding appointment, reappointment and/or Clinical Privileges, or has otherwise had his or her Medical Staff Membership and/or Clinical Privileges at the Hospital revoked or terminated by way of an Adverse Action, shall not be eligible under any circumstances to reapply for Medical Staff Membership or for Clinical Privileges for a period of five (5) years from the date of the final action. Following such period, the Applicant shall then additionally be subject to the basic eligibility requirement set forth in Section 2.2.2.(p). In the event the Applicant requests that an exception be made, as permitted by Section 2.2.2.(p), the MEC and Governing Board (in their discretion) may consider and rely upon any relevant circumstances or information, including but not limited to, the circumstances and information giving rise to the prior Adverse Action(s), as well as the type, nature, and scope of the prior Adverse Action(s).

4.5. Reappointment/Renewal Process

4.5.1. Information Form for Reappointment

The Medical Staff Office or a designated CVO shall, not less than ninety (90) days prior to the expiration date of a Medical Staff appointment and/or expiration of Clinical Privileges, provide the Practitioner with an appropriate reappointment or renewal application form for use in considering reappointment and/or renewal of Clinical Privileges. Each Practitioner who desires reappointment or renewal shall, not less than sixty (60) days prior to such expiration date, submit a fully completed reappointment/renewal application form to the Medical Staff Office or CVO, as

applicable, in addition to any other requested information. In the event the Hospital is unable to fully process a request for reappointment or renewal (as applicable) prior to the expiration of a Practitioner's then current term of appointment and/or Clinical Privileges (as applicable), the Practitioner's Medical Staff Membership and Clinical Privileges (as applicable) shall lapse, and thereafter, the Practitioner must reapply for Medical Staff Membership and/or Clinical Privileges pursuant to the initial appointment process.

4.5.2. Content of Reappointment Application Form

The content of the reappointment/renewal application form shall include, but not be limited to, the applicable information set forth in Section 4.2.2, above. Notwithstanding the foregoing, the timeframe for such requests may be limited to the prior three year period of appointment, and the results of Ongoing Professional Practice Evaluation conducted at the Hospital with respect to the Practitioner over the three year period of reappointment may be utilized, in the discretion of the Credentials Committee and MEC, in lieu of the peer references required by Section 4.2.2(d), above.

4.6. Processing of Reappointment and/or Renewal of Clinical Privileges

4.6.1. Reappointment Burden

The Practitioner applying for reappointment and/or Clinical Privileges shall have the same burden of producing adequate information and resolving doubts as provided in Section 4.4.1, above.

4.6.2. Verification of Information/Complete Application

The same provisions, obligations, and procedures set forth in Section 4.4.2, above, regarding verification of information/complete applications for initial Applicants shall apply to Practitioners seeking reapplication or renewal.

4.6.3. Department/Section, Credentials Committee, MEC, and Governing Board Action

The same provisions, obligations, and procedures set forth in Sections 4.4.3 through 4.4.8, above, shall be followed. For purposes of reappointment or renewal, the term “appointment” as used in those Sections shall be read as “reappointment.” Similarly, “Applicant” shall mean and refer to any Practitioner that is applying for renewal and/or reappointment to the Medical Staff and/or for Clinical Privileges.

4.6.4. Basis for Recommendations

Each recommendation concerning the reappointment of a Medical Staff Member and the Clinical Privileges to be granted upon reappointment, including renewal of Clinical Privileges for an APP, shall be based upon documented evidence of: such Practitioner's eligibility, professional ability and clinical judgment in the care and treatment of patients, professional ethics, discharge of Medical Staff, Department/Section

obligations, discharge of Clinical Privileges compliance with the Bylaws, Policies, and Procedures, cooperation with other Practitioners and with patients, ability to safely practice, the Practitioner's reasonable participation in continuing education activities relevant to his or her Clinical Privileges, and any other matters determined to bear on the Practitioner's ability and willingness to contribute to quality patient care in the Hospital. A Practitioner's eligibility for reappointment of Membership and/or renewal of Clinical Privileges will also be based on compliance with the minimum number of Contacts per each appointment/Clinical Privileges period as required by the applicable Medical Staff Category qualifications and/or established by the Practitioner's Department, Section, the MEC, and/or Governing Board for the purpose of verifying clinical activity, clinical competence, and/or engagement in Medical Staff affairs. Relevant data generated through OPPE, FPPE, and other Peer Review processes at the Hospital will also be considered.

4.7. Requests for Modification of Membership Status or Clinical Privileges

A Practitioner may, either in connection with reappointment or renewal or at any other time, request modification of Medical Staff Category, Department or Section assignment, or Clinical Privileges. A requested change in Medical Staff Category or Department/Section assignment shall be transmitted to the Chief of Staff or designee, whereas a requested change in Clinical Privileges shall be transmitted to the appropriate Department/Section Chairperson. All requests for additional Clinical Privileges must be accompanied by evidence of the Practitioner's education, training, experience and competence to perform the specific Clinical Privileges requested. Such application shall be processed in substantially the same manner as provided in Section 4.6, above, for reappointment.

4.8. Option to Expedite

4.8.1. Expedited Review

(a) In the event an initial Applicant for Medical Staff Membership and/or Clinical Privileges or a Practitioner reapplying for Medical Staff Membership and/or Clinical Privileges evidences or has demonstrated the basic qualifications set forth in the Medical Staff Bylaws, has submitted a Complete Application and otherwise meets all applicable criteria and any applicable regulatory and accrediting agency standards for expedited review, then as an exception to the general credentialing/recredentialing processes set forth above, the Chairperson of the appropriate Department (or Section, if applicable) may elect to initiate (subject to MEC approval in consultation with the Credentials Committee Chairperson) an expedited review process by assessing the Complete Application and forwarding a recommendation directly to the MEC, requesting that the Complete Application be expedited.

(b) The MEC may then review the Complete Application, and if unanimously recommending the Complete Application for approval, may forward the Complete Application and final recommendation to the Governing Board, or a designated subcommittee of the Governing Board consisting of at least two (2) voting Governing Board Members, to review the Complete Application and

take final action thereon. The review and voting functions contained herein may occur in person or by electronic communication, provided there is a voting record of all such activities. All such expedited review activities and determinations are taken by or on behalf of Peer Review Committees of the Medical Staff and Hospital, are expressly contemplated/permitted by such committees pursuant to these Bylaws, and are intended to reduce morbidity and mortality, and to improve the quality of patient care provided at the Hospital. The Hospital, upon recommendation of the MEC, may require an additional application fee be paid by Applicants and re-applicants requesting expedited review.

4.8.2. Restrictions and Objections

An Applicant or Practitioner is ineligible for the expedited credentialing process if, at the time of appointment or granting of Clinical Privileges, or if since the time of last reappointment, any of the following has occurred:

(a) The Applicant or Practitioner submits an incomplete application;

(b) There is a current challenge or a previously successful challenge to the Applicant's or Practitioner's licensure or registration;

(c) The Applicant or Practitioner has received an involuntary termination of medical staff membership at another organization;

(d) The Applicant or Practitioner has received involuntary limitation, reduction, restriction, denial, loss of Clinical Privileges or is otherwise under current focused Peer Review or investigation;

(e) There has been a final judgment that is adverse to the Applicant or Practitioner in a professional liability action; or

(f) There is a reasonable concern about the Applicant or Practitioner's health status.

In addition to the foregoing, if the Chairperson of the Department (or Section, if applicable), the Chief of Staff, or any other Member of MEC participating in the expedited review process, or the Hospital President or Governing Board or any voting Member designated to participate in the expedited review process does not believe an application should be expedited for any reason, the prescribed application and reapplication procedure set forth in these Medical Staff Bylaws shall be followed.

ARTICLE V

CLINICAL PRIVILEGES

5.1. Exercise of Clinical Privileges

Any Practitioner providing direct clinical services at the Hospital shall, in connection with such practice, be entitled to exercise only those Clinical Privileges specifically granted to him/her by the Governing Board. While only Physicians, Dentists, Oral surgeons, Podiatrists and defined categories of APPs are eligible for Medical Staff Membership, other categories of APPs may be granted Clinical Privileges in order to provide clinical services at the Hospital in accordance with the Bylaws, Policies, and Procedures. All Clinical Privileges and services must be within the scope of the Practitioner's license, certificate or other legal authority authorizing him/her to practice in Indiana, and consistent with any applicable restrictions. The care of all patients admitted by an APP, if the APP has been permitted by the Hospital through the APP's granted Clinical Privileges, must be under the care of a Physician Member of the Medical Staff.

5.2. General Delineation of Clinical Privileges

5.2.1. Requests

(a) Each application for appointment and reappointment to the Medical Staff and/or for Clinical Privileges must contain a request for the specific Clinical Privileges desired by the Practitioner.

(b) A request for a modification of Clinical Privileges must be supported by documentation of appropriate training and/or experience supportive of the request and must be consistent with all criteria that have been delineated and established by the Governing Board and Department/Section in which the Practitioner is assigned.

(c) Any request for Clinical Privileges for which there are no approved requirements may be held for a period of up to one hundred twenty (120) days, or for a longer period if determined to be necessary by the Governing Board. During this time, the applicable Department/Section, the Credential Committee, and the MEC may create requirements and formulate the necessary criteria for Clinical Privileges under which the request may be processed for approval by the Governing Board. All requirements for Clinical Privileges will consist of baseline criteria specifying the minimum education, training, experience, and evidence of competency required. All Clinical Privileges are subject to, in the final discretion of the Governing Board, the reasonable resources and capabilities of the Hospital.

5.2.2. Basis for Clinical Privileges Determination

Requests for Clinical Privileges shall be evaluated through the initial appointment and reappointment process outlined above, shall be based on the Practitioner's education, training, certifications, experience, demonstrated ability, judgment, compliance with

the Bylaws, Policies, and Procedures, and should take into consideration the resources and capabilities of the Hospital. If available, the basis for Clinical Privileges determinations shall also include clinical performance as observed or reviewed by the Hospital's performance and/or quality improvement programs. In addition, other factors to be considered shall be the results of focused and ongoing professional practice monitoring and evaluation activities, other quality assurance activities, and whether the Applicant or Practitioner meets any applicable patient contacts requirement. A Clinical Privileges determination shall also be based on pertinent information concerning clinical performance obtained from other sources, such as peers of the Practitioner, and/or from other institutions, especially from health care settings where the Practitioner exercises the clinical privileges that are requested. This information shall be maintained in the quality file established for each Practitioner and shall be the Practitioner's burden to provide, or cause to be provided, if requested.

5.3. Special Conditions for Oral Surgery, Dental, and Podiatric Clinical Privileges

5.3.1. Oral Surgery and Dental Clinical Privileges

Requests for Clinical Privileges from Oral Surgeons and Dentists shall be processed in the same manner as any other Applicant or Practitioner. Procedures performed by Oral Surgeons and Dentists shall be under the overall supervision of the Chairperson of the Department of Surgery or designee. Except with respect to Oral Surgeons who qualify for and receive Clinical Privileges to perform the medical portion of the history and physical, a medical history and physical examination will be made and recorded by a Practitioner who maintains appropriate Clinical Privileges to do so. That Practitioner, and/or another designated Practitioner with appropriate Clinical Privileges, shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed procedure on the total health status of the patient. The Oral Surgeon or Dentist will be responsible for the dental care of the patient, including the dental history and physical examination. Oral surgeons and Dentists may issue orders within their licensed scope of practice and granted Clinical Privileges, and consistent with applicable Bylaws, Policies, and Procedures.

5.3.2. Podiatric Clinical Privileges

Requests for Clinical Privileges from Podiatrists shall be processed in the same manner as any other Applicant or Practitioner. Procedures performed by Podiatrists shall be under the overall supervision of the Chairperson of the Department of Surgery or designee. Except with respect to Podiatrists who are determined to qualify for (by and through additional training and experience) and receive Clinical Privileges to perform the medical portion of the history and physical, a medical history and physical examination will be made and recorded by a Practitioner who maintains appropriate Clinical Privileges to do so. That Practitioner, and/or another designated Practitioner with appropriate Clinical Privileges, shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed

procedure on the total health status of the patient. The Podiatrist will be responsible for the podiatric care of the patient, including the podiatric history and physical examination. Podiatrists may issue orders within their licensed scope of practice and granted Clinical Privileges, and consistent with applicable Bylaws, Policies, and Procedures.

5.4. Special Conditions for Residents and Fellows

Residents and fellows in training in the Hospital (if any) shall not hold Membership on the Medical Staff and/or be granted specified Clinical Privileges. Residents and fellows in training shall be permitted to function clinically in accordance with the written training protocols developed by the MEC or program director in conjunction with the then current residency training program (if any).

Residents or fellows with a medical license and who intend to practice independently in the Hospital, and who meet all other conditions/requirements for Medical Staff Membership and Clinical Privileges, shall be required to apply for and receive appropriate Medical Staff Membership and Clinical Privileges pursuant to the procedures set forth, and subject to all requirements, limitations, and processes, set forth in the Bylaws, Policies, and Procedures.

5.5. Special Conditions for Advanced Practice Professionals and Allied Health Professionals

5.5.1. Credentialing/Supervision

(a) As set forth above, APPs shall be evaluated and credentialed through the Medical Staff credentialing process set forth in the Medical Staff Bylaws. AHPs shall not be evaluated and credentialed through the Medical Staff Credentialing Processes set forth in this Manual, but instead shall be evaluated and credentialed through the Hospital's Human Resources Department and/or other appropriate Hospital Department(s) pursuant to the Hospital's Policies and Procedures.

(b) APPs may only exercise Clinical Privileges on the condition that they are/remain employees of the Hospital, or alternatively, are supervised by or formally collaborate with a designated supervising or collaborative Physician Member of the Medical Staff (to the extent such supervision or collaboration is required by the APP's lawful scope of practice and/or by the Bylaws, Policies, and Procedures). All such APPs must provide evidence, when required, of a current collaborative, supervisory, or employment agreement (as applicable) with a Physician Member of the Medical Staff. APPs may, subject to any licensure requirements or other limitations, exercise independent judgment only within their scope of practice, areas of professional competence, granted Clinical Privileges, and to the extent permitted by the Bylaws, Policies, and Procedures.

(c) AHPs must either be (i) employed by the Hospital (or an authorized Hospital affiliate) or (ii) if expressly permitted by the Bylaws, Policies, and Procedures, may be employed by a Member of the Medical Staff (such that the Member

may lawfully/meaningfully/appropriately supervise the Dependent AHP) or by that Member's professional group or practice (collectively referred to in this Section as the “Employing Physician”).

(d) As set forth above, AHPs employed by the Hospital shall be evaluated and credentialed through the Hospital's Human Resource Department. AHPs may only render professional services under the direct supervision of the Employing Physician Member of the Medical Staff.

5.5.2. Automatic Suspension/Termination

In addition to those applicable administrative remedies and actions set forth in the Corrective Action and Fair Hearing Manual, the following shall apply:

(a) The Membership, Clinical Privileges, and/or credentials of an APP or AHP (as applicable) shall administratively terminate, effective immediately and without recourse to any procedural rights set forth elsewhere in the Medical Staff Bylaws, in the event that the APP's or AHP's employment by, or professional services contract (directly or through an affiliated entity) with, the Hospital or Employing Physician (as applicable) terminates for any reason.

(b) The Membership, Clinical Privileges, and/or credentials of an APP or AHP (as applicable) shall administratively suspend, effective immediately and without recourse to any procedural rights set forth elsewhere in the Medical Staff Bylaws, in the event that a required supervisory or collaborative agreement with a Member of the Medical Staff is terminated for any reason. The a APP or AHP shall be permitted a period of thirty (30) days, commencing on the date the supervisory or collaborative agreement (as applicable) terminates, to enter into a new or alternate supervisory or collaborative agreement (as applicable and required by law) with another qualified Member of the Medical Staff. If the APP or AHP fails to enter into a new or alternate, legally valid, supervisory or collaborative agreement (as applicable and required by law) prior to the expiration of thirty (30) days, then the suspension shall be automatically converted to a termination of Membership, Clinical Privileges, and/or credentials (as applicable). Such termination shall constitute an Administrative Action, and thus, shall be without recourse to any procedural rights set forth elsewhere in the Medical Staff Bylaws.

5.5.3. Responsibilities of Employing or Collaborative/Supervising Member

(a) The number of APPs or AHPs acting as employees of and/or under the collaboration/supervision of one (1) Member of the Medical Staff, as applicable, as well as the actions that the APP(s) or AHP(s) may undertake, shall be consistent with applicable Law, as well as all applicable Bylaws, Policies, and Procedures.

(b) It shall be the responsibility of the collaborating or supervising Member of the Medical Staff to countersign all medical record entries made by the APP or AHP if required by applicable Bylaws, Policies, and Procedures.

(c) APPs and AHPs must maintain professional liability insurance, in the form and amounts required by the Governing Board, to cover any and all activities of the APP or AHP at the Hospital and must furnish evidence of such coverage to the Hospital. An APP shall exercise Clinical Privileges only while such coverage is in effect.

5.5.4. Hospital Employed APPs and AHPs

(a) Except as provided in paragraph (b) immediately below, the employment of an APP or AHP by the Hospital shall be governed by the Hospital's employment policies and the terms of the individual's employment relationship. If the Hospital's employment policies, or the terms of any applicable employment relationship are more restrictive than, or conflict with, the Medical Staff Bylaws, the employment policies or terms of the individual's employment relationship shall take priority.

(b) If concerns or complaints about a Hospital employed APP clinical competence or professional conduct originates with the Medical Staff, the concern may be reviewed and addressed in accordance with the pertinent provisions set forth in the Corrective Action and Fair Hearing Manual. Concerns or complaints about a Hospital employed AHP shall be reported to and addressed by the Hospital's Human Resources Department.

5.6. Telemedicine Clinical Privileges

5.6.1. Appointment to Medical Staff

Applicants seeking appointment to the Medical Staff and/or Clinical Privileges to perform telemedicine services may, but need not, be processed pursuant to the complete appointment and privileging procedures described above. Further, such Applicants may be exempted by the MEC from particular Medical Staff requirements/obligations that are not applicable by virtue of the Applicant's distant site practice (including but not limited to vaccination requirements, meeting attendance requirements, and other such requirements/obligations). Subject to the conditions specified below, Applicants who intend to provide telemedicine services under a written agreement between the Hospital and a distant-site hospital or entity, the MEC may make recommendations to the Governing Board regarding such Applicants in reliance upon the credentialing and privileging decision of the distant-site hospital or entity with whom the Hospital has an agreement for telemedicine services.

5.6.2. Applicants from Distant-Site Hospitals or Telemedicine Entities

Applicants based at distant-site hospitals or entities who intend to provide telemedicine services under a written agreement with the Hospital may apply for such telemedicine Clinical Privileges and appointment to the Affiliate Staff provided each Applicant meets the basic qualifications for appointment set forth above and by submission of the same application or application with equivalent content as specified above. Determinations regarding equivalent content will be made by the MEC, subject to Governing Board approval.

5.6.3. Credentialing of Applicants from Distant-Site Hospitals or Telemedicine Entities

Upon confirmation by the Medical Staff Office that an Applicant's request for appointment and telemedicine Clinical Privileges complies with the terms of the written agreement between the Hospital and the distant-site hospital or entity, including Clinical Privileges criteria adopted by the Medical Staff, the MEC may rely upon the credentialing and privileging decisions made by a distant-site hospital or telemedicine entity when making its recommendation for appointment and Clinical Privileges provided the Agreement between the Hospital and distant-site hospital or telemedicine entity (minimally) ensures the following:

(a) The distant-site hospital is a Medicare participating hospital or the distant-site telemedicine entity provides written assurances that its credentialing and privileging process and standards meet the Medicare Conditions of Participation for Hospitals;

(b) The distant-site hospital or distant-site telemedicine entity, as applicable, meets all other pertinent accreditation requirements to which the Hospital may be subject;

(c) The Applicant/Member is privileged at the distant-site hospital or distant-site telemedicine entity and a current list of equivalent privileges is provided;

(d) The Applicant/Member holds a current license issued or recognized by the State of Indiana, and complies with any Indiana-specific certification/registration requirements;

(e) The Applicant/Member meets the professional liability insurance requirements established by the Governing Board; and

(f) That upon being granted Membership and/or Clinical Privileges, the Hospital provides the distant-site hospital or entity evidence of an internal review of the Practitioner's clinical performance for use in the Practitioner's periodic appraisal and, at a minimum, the information must include all adverse events resulting from the telemedicine services provided by the distant-site Practitioner as well as any registered complaints.

5.6.4. Failure to Utilize Clinical Privileges

If a Practitioner who has been granted Clinical Privileges to provide telemedicine services at the Hospital fails to utilize such Clinical Privileges or otherwise provide telemedicine services to Hospital patients at a satisfactory volume as set forth in the Bylaws, Policies, and Procedures (if addressed/applicable) for the purpose of reliably assessing the quality and performance of the Practitioner's telemedicine services, the Practitioner shall be deemed to have voluntarily withdrawn his or her Medical Staff Membership and/or Clinical Privileges, as applicable, effective either six (6) months following the date Practitioner last provided telemedicine services at the Hospital or when otherwise acknowledged by the Medical Staff. Such voluntary withdrawal shall constitute an Administrative Action.

5.6.5. Temporary Clinical Privileges for Telemedicine Applicants

If the Hospital has not entered into a written agreement for telemedicine services with a distant-site hospital or entity but has a pressing clinical need for telemedicine services and a distant-site Applicant can supply such services via a telemedicine link, the Hospital may evaluate the use of temporary Clinical Privileges for a distant-site Applicant as addressed in Section 5.7 below. In such cases, the distant-site Practitioner must be credentialed and privileged to provide telemedicine services in accordance with Hospital standards and procedures applicable to the approved telemedicine services.

5.6.6. Telemedicine Practice

Clinical practice through telemedicine link is at all times subject to the approval of the Hospital and Medical Staff. Further, such practice, when permitted, shall be subject to all applicable Hospital and Medical Staff Bylaws, Rules, Regulations, Policies, and Procedures.

5.7. Temporary Clinical Privileges

5.7.1. Circumstances

The Hospital President or authorized designee, acting on behalf of the Governing Board, may grant specific temporary Clinical Privileges in the circumstances described below. Temporary Clinical Privileges may, in the discretion of the Hospital President or authorized designee, be conditioned upon the Applicant or Member successfully completing any Hospital sponsored training programs related to electronic medical record (EMR) and related clinical system implementation, passing any related program examination or opt-out examination, and submitting required program documentation prior to review of request for temporary Clinical Privileges.

(a) Pendency of Application

Upon receipt of a Complete Application for Medical Staff Membership and/or Clinical Privileges, and after receiving a favorable recommendation by the

Chief of Staff (or authorized designee) and the applicable Department Chairperson (or authorized designee), an appropriately licensed Physician, Dentist, Oral Surgeon, Podiatrist, or APP who is an Initial Applicant or a Practitioner requesting new or additional Clinical Privileges may be granted temporary Clinical Privileges for a period of up to one hundred twenty (120) days, pending complete Medical Staff and Governing Board evaluation pursuant to the processes set forth in these Medical Staff Bylaws. In exercising such temporary Clinical Privileges, the Applicant shall act under the supervision of the Chairperson of the Department (or authorized designee, who may be the applicable Section Chairperson) to which he or she is assigned and in accordance with the conditions specified in Section 5.7.2, below.

(b) Important Patient Care, Treatment, Service Need

Upon receipt of a request (which should be in writing whenever reasonably possible) directed to the Hospital President and Chief of Staff (or their authorized designees), and after receiving a favorable recommendation by the Chief of Staff (or authorized designee) and the applicable Department Chairperson (or authorized designee), a duly licensed Physician, Dentist, Oral Surgeon, Podiatrist, or APP of documented competence may be granted temporary Clinical Privileges for the care of one or more specific patients. Such temporary Clinical Privileges shall only be granted under extraordinary circumstances, may be limited by the Hospital President to a specified number or type of patients, and shall be exercised in accordance with the conditions specified in Section 5.7.2, below. The granting of temporary privileges for this purpose is not precipitous, and occurs only after (minimally):

(i) Verification of licensure, Drug Enforcement Administration (DEA) registration, any state required controlled substance registration, and professional liability insurance in such amounts that are required by the Governing Board, and

(ii) At least one recent reference from a previous hospital, chief of staff, or department chair.

(c) Locum Tenens

Consistent with extending temporary Clinical Privileges for important patient care need, as set forth above, upon receipt of a request (which should be in writing whenever reasonably possible) directed to the Hospital President and Chief of Staff (or their authorized designees), and after receiving a favorable recommendation by the Chief of Staff (or authorized designee) and the applicable Department Chairperson (or authorized designee), a duly licensed Physician, Dentist, Oral Surgeon, Podiatrist, or APP of documented competence who will serve in a locum tenens capacity in order to satisfy an important patient care, treatment, or service need may be granted temporary Clinical Privileges for a period up to one hundred twenty (120) days. Such temporary Clinical Privileges shall be exercised in accordance with the

conditions specified in Section 5.7.2, below. The granting of temporary privileges for this purpose is not precipitous, and occurs only after receipt and evaluation of a Complete Application. Locum Tenens providers shall only be permitted to admit patients to the Hospital to the extent such admission(s) are within the scope of the locum tenens coverage being provided and are permitted by the temporary Clinical Privileges that have been granted.

5.7.2. Additional Conditions

Special requirements of consultation and reporting may be imposed by the Department and/or Section Chairperson responsible for supervision of a Practitioner granted temporary Clinical Privileges. Before temporary Clinical Privileges are granted, the Practitioner must acknowledge in writing that he or she has received, or has otherwise been provided access to, and has read the applicable Bylaws, Policies, and Procedures, and that he or she agrees to be bound by the terms thereof in all matters relating in any fashion to the temporary Clinical Privileges.

5.7.3. Suspension

On the discovery of any information or the occurrence of any event of a nature which raises questions about a Practitioner's professional qualifications, professional conduct, or ability to appropriately or safely exercise any or all of the temporary Clinical Privileges granted, temporary Clinical Privileges may be summarily suspended by any of the individuals identified in the Corrective Action and Fair Hearing Manual as eligible to invoke a summary suspension. In the event of such suspension, the Practitioner's patients then in the Hospital shall be assigned to a Medical Staff Member(s) by the applicable Department Chairperson (or authorized designee), who may also delegate such task to an applicable Section Chairperson. The wishes of patients shall be considered, where feasible, in choosing a substitute Practitioner. The substitute Practitioner(s) shall have the right to refuse to accept such patient assignments, in which case the Chairperson (or authorized designee) shall assign the patients to another substitute Practitioner(s).

5.7.4. Rights of a Practitioner with Temporary Clinical Privileges

By applying for temporary Clinical Privileges, all Practitioners acknowledge the expected short-term nature of such status and that such status does not confirm Membership, or an expectation of Membership, on the Medical Staff. Accordingly, all such Practitioners expressly agree that the Practitioner shall **not** be entitled to the procedural rights afforded by the Corrective Action and Fair Hearing Manual (if any) in the event: a request for temporary Clinical Privileges is refused or denied, or (if such temporary Clinical Privileges are granted) all or any portion of the temporary Clinical Privileges are summarily suspended, restricted in any fashion, and/or terminated. All such actions constitute Administrative Actions.

5.8. Emergency Clinical Privileges

For the purpose of this Section, an “emergency” is defined as a condition in which serious or

permanent harm would result to a patient or bystander or in which the life of a patient or bystander is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any Practitioner shall be permitted and assisted to do everything possible (within the scope of the Practitioner's license) to save the life of a patient or prevent serious harm, using every facility of the Hospital necessary, including the calling of any consultation necessary or desirable, regardless of his or her Department, Section, Medical Staff status, or Clinical Privileges. The Practitioner shall make every reasonable effort to communicate promptly with the appropriate individuals concerning the need for emergency care and assistance by Members of the Medical Staff with appropriate Clinical Privileges, shall promptly yield such care to qualified Members of the Medical Staff when it becomes reasonably available, and once the emergency has passed or assistance has been made available, shall defer to the appropriate Department Chairperson and/or Section Chairperson (as applicable) with respect to further care of the patient.

5.9. Disaster Clinical Privileges

5.9.1. Circumstances

Any individual intending to provide services during a disaster event must be granted Clinical Privileges prior to providing patient care. Disaster privileges are considered temporary in nature.

5.9.2. Conditions

(a) The Hospital President or Chief of Staff, or their respective designees, in circumstances of disaster in which the Hospital's emergency operation plan has been activated, shall have the authority to grant disaster privileges to a Physician, Dentist, Oral Surgeon, Podiatrist, or APP who is not a Member of the Medical Staff subject to the process and conditions set forth in this Section.

(b) Decisions regarding the granting of disaster privileges are made on a case-by-case basis. The Hospital President and Chief of Staff, or their respective designees, are not required to grant privileges to any individual. Prior to granting such privileges, the Hospital President or Chief of Staff or their designee shall verify information regarding the individual upon presentation of a valid government issued photo identification card and at least one (1) of the following:

(i) A current picture identification card from a health care organization that identifies the Practitioner's professional designation;

(ii) A current license to practice;

(iii) Primary source verification of licensure;

(iv) Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health

Professionals (ESAR-VHP), or other recognized state or federal response organization or group;

(v) Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity; or

(vi) Confirmation by a Practitioner who is currently privileged by the Hospital with personal knowledge regarding the Practitioner's ability to act as a licensed independent Practitioner during a disaster.

(c) Primary source verification of licensure, certification, or registration (if required by Law in order to practice), as well as verification of credentials under these Medical Staff Bylaws for granting temporary Clinical Privileges, shall begin as soon as the disaster is under control, but no later than seventy-two (72) hours. In extraordinary circumstances, primary source verification and/or evaluation for temporary Clinical Privileges of credentials may occur later than seventy-two (72) hours and as soon as possible. In such case, the Hospital shall document the reasons for any delay, evidence of the health care provider's demonstrated ability to continue to provide adequate care, treatment and services and evidence of the Hospital's attempt to perform credentialing verification in a timely manner.

(d) The MEC or designee will oversee the performance of individuals granted disaster privileges by either direct observation, mentoring or medical record review as may be more fully described in the Hospital's emergency operation plan.

(e) The Hospital President or designee will determine within seventy-two (72) hours of each Practitioner's arrival whether granted disaster privileges should continue.

5.10. History and Physical Examination Requirements

A medical history and physical examination, which is signed or cosigned by a Physician, must be completed in-person and documented for each patient in accordance with the Bylaws, Policies, and Procedures, and as required by Law. In all instances, a history and physical exam must be performed and documented within thirty (30) days prior to date of admission or within twenty-four (24) hours after an admission. If a history and physical is performed and documented in the chart prior to the date of admission, then a thorough updating entry must be provided within twenty-four (24) hours after the admission, which documents/addresses vital signs, systems stability, or other relevant change, and any other information pertinent to the admission. With respect to surgical patients, in all such cases there must be a history and physical workup in the chart prior to surgery, except in emergencies. If the report has been dictated, but not yet recorded in the patient's chart, there shall be a statement to that effect and an admission note in the chart by the admitting Physician, which includes vital signs, allergies, and appropriate data.

5.11. Impaired Member or APP

(a) An impaired Practitioner is one who is unable to render professional services with reasonable skill and safety to patients due to a physical or mental illness or condition, whether caused by cognitive decline, loss of motor skills, the excessive use or abuse of drugs, including but not limited to alcohol, or other problems affecting his or her ability to practice effectively and/or safely. The Medical Staff requires that all Practitioners who are granted Clinical Privileges be and remain able to: exercise such Clinical Privileges, engage in professional practice, and participate in Hospital and Medical Staff related functions and events without impairment. All Practitioners agree, as a condition of ongoing Medical Staff Membership and/or Clinical Privileges (as applicable), to such requirements, and further, agree to abide by all Bylaws, Policies, and Procedures, as well as the MEC's authority, in relation to addressing potential Practitioner impairment. All Practitioners additionally agree, as a condition of ongoing Medical Staff Membership and/or Clinical Privileges (as applicable), to **confidentially and promptly** report impairment concerns pursuant to the Bylaws, Policies, and Procedures. Any questions or concerns in relation to applicable policies or procedures should be directed to the Hospital President, Chief of Staff, VPMA, or any member of the MEC or Physician Assistance Committee (if applicable). At the discretion of the Hospital President, impairment concerns related to employed Practitioners may be addressed pursuant to the Hospital's human resources policies for individuals employed by the Hospital and for individuals who work for a group under contract with the Hospital.

(b) The MEC, or other designated Medical Staff committee, will address Practitioner impairment matters in a confidential, unbiased manner while striving to protect patient safety and the rights of the applicable Practitioner. The MEC is under no obligation to evaluate or treat an impaired Practitioner, as this is an obligation of the Practitioner's personal physician or other health care providers. The MEC, in its discretion, may rely upon evaluations and assessments by the Practitioner's providers and/or independent practitioners to determine whether a Practitioner is safe to practice. This determination may involve establishing conditions that the Practitioner must meet to continue practicing, which may include, but are not limited to: random drug screens, regular appointments with a psychologist, psychiatrist or other appropriate health care provider; imaging, laboratory or other diagnostic studies; proof of attendance at treatment related meetings; and/or a conditional leave of absence. If there is sufficient evidence supporting impairment and if a Practitioner fails to satisfy any conditions imposed by the MEC, or if quality of care or patient safety are at risk, a Practitioner's Membership and/or Clinical Privileges (as applicable) may be suspended pending further investigation and potential action in accordance with the Corrective Action and Fair Hearing Manual.

5.12. Outpatient Diagnostic Services

Physicians, Dentists, Oral Surgeons, Podiatrists, or APPs with an independent scope of practice who are not Members of the Medical Staff or who do not have Clinical Privileges may order outpatient diagnostic services and outpatient therapeutic services (e.g. physical therapy, occupational therapy or speech therapy) for their patients if it is within their permitted scope of practice to do so. However, all non-affiliated Physicians, Dentists, Oral Surgeons, Podiatrists, and APPs who desire to order such services must provide evidence of the following qualifications:

(a) an unlimited license to practice their specialty; and

(b) their ability to participate in Medicare and other federally funded health care programs.

All Physicians, Dentists, Oral Surgeons, Podiatrists, and APPs who are not Members of the Medical Staff or who do not have Clinical Privileges at the Hospital must also provide accurate and complete contact information at the time any service is ordered. The Hospital or Medical Staff may, at any time and for any reason, refuse to accept a request for an outpatient diagnostic service.

Notwithstanding the foregoing, all Physicians, Dentists, Oral Surgeons, Podiatrists, or APPs who do not maintain Clinical Privileges at the Hospital and who seek to order outpatient services are subject to the Hospital's prevailing policy related to such outpatient orders, including all restrictions contained therein. If the Hospital does not maintain such a policy, or if such policy does not address restrictions on outpatient orders, then by operation of this Section, such practitioners may not order infusion services, radiation services, nuclear medicine services, or other invasive services as may be determined in the discretion of the MEC.

5.13. Focused and Ongoing Professional Practice Evaluation

As part of its ongoing quality improvement activities, and in compliance with Law, the Hospital engages in both Focused and Ongoing Professional Practice Evaluation.

(a) Focused Professional Practice Evaluation ("FPPE") at the Hospital is intended to serve two purposes:

(i) The Peer Review evaluation, for privilege-specific competency, of (a) new Practitioners at the Hospital seeking Clinical Privileges and of (b) current Practitioners at the Hospital that have requested to receive new or additional Clinical Privileges; and

(ii) The Peer Review evaluation of Practitioners at the Hospital where specific performance related concerns implicating patient safety and/or quality of care are identified.

(b) Ongoing Professional Practice Evaluation ("OPPE") is a systematic and ongoing Peer Review process used to evaluate and confirm the current competency of those Practitioners with Clinical Privileges at the Hospital. OPPE is intended to assist the Medical Staff with identifying and resolving Practitioner related performance concerns or trends that may adversely impact patient safety or quality of care. OPPE is intended to foster an efficient, evidence-based privilege monitoring and renewal process. Information generated through OPPE will be used to evaluate the qualifications of Practitioners, including determinations to continue, limit, or revoke any existing privileges(s). Information generated through OPPE, within the requirements of Peer Review confidentiality, will also be utilized for more systematic performance improvement activities intended to maintain or improve patient safety and quality of care.

The applicable and detailed policies and processes for FPPE and OPPE are set forth in the Medical Staff Policy for OPPE and FPPE.

ARTICLE VI

MEDICAL STAFF OFFICERS

6.1. Medical Staff Officers

The following Medical Staff Officers shall be Members of the Active Staff who fulfill necessary governance functions of the Medical Staff and who represent the needs and interests of the entire Medical Staff:

(a) Chief of Staff;

(b) Vice Chief of Staff;

(c) Secretary-Treasurer.

6.2. Qualifications

Officers must be Members of the Active Staff at the time of nomination and election, and must remain Members of the Active Staff in good standing during their term of office. No Member under consideration by the Nominating Committee for an officer position may be under current investigation by the Medical Staff or have had significant or repeated quality of care or professional conduct issues. Nominees should have a reputation for leadership and excellent patient care services, and be willing to serve in a leadership position. Failure to maintain such status shall immediately result in the Member's disqualification to hold office. The Nominating Committee will have the discretion to determine if a Member desiring to run for office meets these qualifying criteria. Any Member who is nominated must disclose to the Nominating Committee his or her ineligibility to hold office when considering the qualifications in this Section.

In order to avoid conflicts of interest, Officers may not simultaneously serve as an officer on the Medical Staff of a hospital that is unaffiliated with System and that is located in the Hospital's geographic service area unless the Board determines, in its sole discretion, to make an exception for good cause. Noncompliance with this requirement will result in the Officer being automatically removed from office unless the Governing Board determines in consultation with the MEC that allowing the Officer to maintain his/her position is in the best interest of the Hospital. The Governing Board, in consultation with the MEC, shall have the sole discretion to determine eligibility/ineligibility pursuant to this section. Any action taken to remove or disqualify a Member pursuant to this section shall constitute an Administrative Action.

6.3. Nominations

6.3.1. Nominating Committee

Prior to the expiration of the current Officer terms, the MEC shall appoint a Nominating Committee comprised of at least three (3) Members of the Active Staff, as well as the VPMA, who shall serve as an ex officio member without vote. If there is no VPMA, then the Hospital President (or authorized designee) shall serve as an ex officio member without vote. This Nominating Committee shall offer one or more nominees for each open office. Nominations shall be transmitted to all Members of the Active Staff at least thirty (30) days prior to the Annual Meeting (or Special Meeting if required) where such vote shall occur. Notwithstanding the foregoing, the MEC may elect to serve as the Nominating Committee. However, if it does so, the MEC must indicate that it served in this capacity as part of the notice of nominees that is transmitted to the Members of the Active Staff (per above).

6.3.2. By Petition

Nominations may also be made by petitions signed by at least two (2) Members of the Active Staff and submitted to the current Secretary-Treasurer at least fifteen (15) days prior to the Annual Meeting (or Special Meeting if required) where such vote shall occur. The names of these additional nominees shall be transmitted to all Members of the Active Staff at least five (5) days prior to the Annual Meeting where such vote shall occur.

6.3.3. Failure to Timely Nominate

In the event, for any reason, no candidate(s) has/have been timely nominated pursuant to the provisions above, the MEC shall nominate one or more candidates and shall serve notice of same to all Members of the Active Staff prior to the Annual Meeting (or Special Meeting if required) where such vote shall occur. If the MEC fails (or otherwise elects not) to timely do so, then nominations shall be made by one or more eligible Members at the meeting where the vote is to occur.

6.4. Election of Officers

New Officers shall be elected at the Annual Meeting (or Special Meeting if required) of the Medical Staff by Members of the Active Staff. Voting shall be by secret written ballot. A Member of the Active Staff who is eligible to vote, but who cannot be present at the Annual Meeting (or Special Meeting if required), may cast an absentee ballot by designated electronic ballot pursuant to the balloting procedures set forth below with respect to Medical Staff Meetings. Alternatively, in the discretion of the Chief of Staff, voting may be accomplished by way of subsequent mailed or electronic ballot, as set forth in Section 9.4, below.

6.5. Terms

Each Officer shall serve a two year (2) term, commencing on the first day of the Medical Staff Year following his/her election or appointment (as applicable). Each Officer shall serve until the end of term and/or until a successor is elected, unless he/she shall sooner resign or be removed from office. There shall be no term limits and Officers may serve successive terms.

6.6. Removal

The MEC, by a two-thirds vote, may remove any Medical Staff Officer. Removal may be based upon the loss of a Member's eligibility to maintain the Office, or by demonstrating a material failure to perform (in the discretion of those groups eligible to initiate removal) any of the duties of the position. The removal of an Officer shall constitute an Administrative Action. An Officer shall be afforded the opportunity to respond to the stated concern(s) prior to the MEC's vote on such removal.

6.7. Vacancies

If there is a vacancy in the Office of Chief of Staff, the Vice Chief of Staff shall serve out the remaining term. All other vacancies shall be filled by the MEC if the remaining term is less than six (6) months and by a special election of the Active Staff at its next scheduled meeting (or thereafter by subsequent mailed or electronic ballot in the discretion of the Chief of Staff, as set forth in Section 9.4, below) if the remaining term is greater than six (6) months.

6.8. Duties

6.8.1. Chief of Staff

(a) The Chief of Staff shall serve as the chief administrative officer of the Medical Staff. His or her responsibilities shall be to:

(i) Represent the views, policies, needs and grievances of the entire Medical Staff to the Governing Board, Hospital President, and VPMA (when a VPMA has been appointed);

(ii) Work with the Hospital President and VPMA (when a VPMA has been appointed) in all matters of mutual concern within the Hospital;

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

(iv) Serve as Chairperson of the MEC;

(v) Serve as an ex officio Member of all other Medical Staff committees, except the Nominating Committee;

(vi) Be responsible for the enforcement of the Medical Staff Bylaws, for implementation of corrective action activities and sanctions where indicated, and for the Medical Staff's compliance with the procedural safeguards in all instances where corrective action has been requested against a Practitioner;

(vii) Appoint Members and Chairpersons of each standing, special, and multidisciplinary Medical Staff committee, except the MEC, Credentials Committee, Department Committees, and as may otherwise be expressly provided in the Bylaws, Policies, and Procedures;

(viii) Be responsible, as Chairperson of the MEC, for carrying out quality assessment and performance improvement functions of the Medical Staff;

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

(x) Authorize expenditures of Medical Staff funds as provided herein; and

(xi) Perform such other functions as may be required by the Bylaws, Policies, and Procedures, and/or that may be assigned by the Members, by the MEC, or by the Governing Board.

(b) When undertaking these responsibilities, the Chief of Staff is acting at all times on behalf of, and subject to, the MEC's authority.

6.8.2. Vice Chief of Staff

(a) He or she shall generally assist the Chief of Staff as may be requested and shall perform such other duties as may be required by the Bylaws, Policies, and Procedures, and/or that may be assigned by the Chief of Staff, by the MEC, or by the Governing Board.

(b) In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff.

(c) He or she shall be a Member of the MEC and such other Medical Staff committees as may be prescribed by the Bylaws, Policies, and Procedures.

6.8.3. Secretary-Treasurer

(a) The Secretary-Treasurer will assist to ensure maintenance of appropriate minutes, act as Medical Staff treasurer, generally assist the Chief of Staff as may be requested, and shall perform such other duties as may be required by the Bylaws, Policies, and Procedures, and/or that may be assigned by the Chief of Staff, by the MEC, or by the Governing Board.

(b) In the absence of the Chief of Staff and the Vice Chief of Staff, the Secretary-Treasurer shall assume all the duties and have the authority of the Chief of Staff.

(c) Similarly, in the absence of the Vice Chief of Staff, the Secretary-Treasurer shall assume all the duties and have the authority of the Vice Chief of Staff.

(d) He or she shall be a Member of the MEC and shall be a member of such other Medical Staff committees as may be prescribed by the Bylaws, Policies, and Procedures.

6.9. Use of Designees

Any Medical Staff Officer may delegate certain tasks and activities to various designees, including but not limited to the VPMA (when a VPMA has been appointed) and Hospital President, to assist the Officer in fulfilling his or her duties and responsibilities, which may include activities related to credentialing, privileging, and other such Peer Review activities.

ARTICLE VII

CLINICAL DEPARTMENTS AND SECTIONS

7.1. Organization of Clinical Departments and Sections

The Medical Staff shall be organized into Departments, and when determined to be appropriate, Sections within these Departments. Each Clinical Department and Section shall be organized as a separate unit of the Medical Staff. Departments shall have a Chairperson and Vice Chairperson who shall be responsible for the overall supervision and administrative work within the Department. Sections shall have a Chairperson, and may have a Vice Chairperson, who shall be responsible for the overall supervision and administrative work within the Section. There should be no fewer than three (3) Active Staff Members in an established Department or Section.

Each Clinical Department and Section of the Medical Staff, as well as all standing committees, subcommittees, and ad hoc committees appointed by or on behalf of a Clinical Department or Section, is hereby constituted as Peer Review Committee, consistent with Law, and as further defined in these Medical Staff Bylaws.

7.1.1. Current Departments and Sections

The current Departments are as follows:

(a) Anesthesiology;

(b) Cardiovascular Services;

(c) Emergency Medicine;

(d) Family Medicine;

(e) Gastroenterology

(f) Hospitalist Medicine;

(g) Medicine;

(h) Obstetrics/Gynecology;

(i) Ophthalmology;

(j) Oral/Dental Surgery;

(k) Orthopedics;

(l) Otolaryngology/Head and Neck Surgery;

(m) Pathology;

(n) Pediatrics;

(o) Psychiatry;

(p) Radiology; and

(q) Surgery.

There are no current Sections organized within the above Departments.

7.1.2. Future Departments and Sections

The MEC shall periodically restudy the structure set forth above and recommend to the Governing Board what action is desirable, if any, with respect to changing, adding and/or deleting the Departments or Sections for better organizational efficiency and improved patient care. In arriving at its recommendation(s), the MEC shall consider (in addition to any other appropriate and relevant factors):

(a) The number of Applicants and Members who are available for appointment to and who are, or are reasonably expected to be, active participants in the Department or Section; and

(b) Whether the level of actual or anticipated clinical activity is sufficient to warrant imposing the responsibility to accomplish Departmental and Section functions on a routine basis.

7.2. Functions of Departments and Sections

The primary responsibility delegated to each Department, subject to MEC's final authority and oversight, is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Department. Sections that are established within a Department shall be responsible to the Department and shall assist the Department with its functions. Accordingly, each Department and Section shall:

(a) Monitor and evaluate specific aspects of the quality and appropriateness of patient care, investigate trends or problems referred to it, and send to the appropriate Committee written reports of the Department's or Section's findings, conclusions, recommendations, actions and follow-up with respect to all patient care and Peer Review matters;

(b) Conduct ongoing monitoring and evaluation of all clinical aspects of patient care as required by the applicable regulatory and accreditation agencies or as required by law. Each Department and Section shall review, in collaboration with other Departments, as appropriate, all clinical work performed under its authority, including those instances where a Practitioner may be a Member of more than one Department or Section or whether any particular Practitioner whose practice is subject to such review is a Member of that Department or Section. Practitioners shall be subject to review by each Department in which they exercise Clinical Privileges;

(c) Establish guidelines for Membership in the Department or Section and for the granting of Clinical Privileges and the performance of specified services within the Department or Section, and submit to the Credentials Committee the recommendations required under the Medical Staff Bylaws regarding appointment and reappointment of Medical Staff Members or the granting of Clinical Privileges. Recommendations for reappointment or the granting of Clinical Privileges shall include consideration of the Practitioner's quality assessment and improvement record;

(d) Develop clinical policy, monitor, evaluate, and improve the quality of care provided in associated hospital areas;

(e) Conduct, participate in, and make recommendations regarding the need for continuing medical education programs pertinent to changes in the standard of care or state-of-the-art, and to findings of review, evaluation and monitoring activities;

(f) Monitor, on a continuing and concurrent basis, adherence to: (1) Medical Staff and Hospital policies and procedures including any and all ongoing and/or

focused monitoring and evaluation of Practitioner performance; (2) requirements for alternate coverage and consultations; (3) sound principles of clinical practice and judgment; (4) regulations designed to promote patient safety;

(g) Coordinate the patient care provided by the Department's or Section's Medical Staff Members and other Practitioners with patient care service obligations, other ancillary services and administrative support services;

(h) Submit, through the Department Chairperson, written reports to the MEC on a regularly scheduled basis concerning: (1) findings of the Department's review, evaluation and monitoring activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided in the Hospital; and (3) such other matters as may be requested from time to time, or otherwise required, by the MEC or Hospital;

(i) Meet as often as necessary, but no less than once per year, for the purpose of reviewing the findings and results of the Department's or Section's ongoing evaluation and monitoring activities as well as the reports of other Medical Staff committees as set forth in the Medical Staff Bylaws and related policies; and

(j) Establish such subcommittees or other appropriate mechanisms as are necessary and desirable to properly perform the functions assigned to it.

7.3. Department and Section Policies and Procedures

Each Medical Staff Department may adopt and implement various policies and procedures, subject to MEC approval, that apply to the Department and/or Section membership and that are intended to fulfill the Department's and/or Section's obligations and functions within the Medical Staff as described herein, provided such policies and procedures do not conflict with these Medical Staff Bylaws, the Hospital Bylaws, Hospital or System policies, applicable accreditation standards, or applicable Federal or State law. Any Department or Section policy or procedure that conflicts or is otherwise inconsistent with these conditions, as determined by the MEC or Governing Board, shall be considered void and without effect.

7.4. Qualifications, Selection, and Tenure of Department and Section Chairpersons and Vice Chairpersons

7.4.1. Qualifications

(a) Each Department and Section Chairperson and Vice Chairperson shall be a Member in good standing of the Active Staff and shall be qualified by training, experience, administrative ability, and clinical and professional leadership qualities necessary for the position. Department and Section Chairpersons and Vice Chairpersons must be board certified by an appropriate specialty board as set forth in Section 2.2.3 above.

(b) In the event that a board certified Practitioner is not available to serve as Department or Section Chairperson or Vice Chairperson, the Chief of Staff may, with the approval of the MEC, accept the nomination of an interim Chairperson or Interim Vice Chairperson as a candidate for office. The Interim Chairperson or Vice Chairperson shall retain the position for the two (2) year term and may only run for re-election if he or she obtains certification.

7.4.2. Nomination and Election of Department Chairpersons and Vice Chairpersons

(a) Each Department, by way of the Active Members assigned to that Department, shall elect by designated (confidential) electronic or written ballot a Chairperson and Vice Chairperson for a term of two (2) years at a meeting held in conjunction with the Annual Meeting of the Medical Staff (or if necessary at the first Department meeting following the Annual Meeting). Alternatively, voting may be accomplished by way of subsequent mailed or electronic ballot, as set forth in Section 9.4, below. The Medical Staff Secretary-Treasurer will accept nominees up to thirty (30) days prior to the Annual Meeting. A list of candidates for Department Chairperson and Vice Chairperson will thereafter be transmitted to each eligible Department Member at least ten (10) days prior to the Annual Meeting (or Department meeting if required).

(b) A Member of the Active Staff who is eligible to vote, but who cannot be present at the Annual Meeting (or Department meeting if required), may cast an absentee ballot by designated electronic ballot pursuant to the balloting procedures set forth below. There will be a separate election for Chairperson and Vice Chairperson.

(c) In the event of a tie vote for the election of a Chairperson or Vice Chairperson, the MEC shall vote to break the tie. In the event of a tie vote at MEC, the Chief of Staff shall break the tie. In the event the Medical Staff Secretary-Treasurer receives no timely nominations for a Department Chairperson or Vice-Chairperson prior to the election, the Chief of Staff shall appoint a Member to serve in such position(s).

7.4.3. Nomination and Election of Section Chairpersons and Vice Chairpersons

(a) Each Section, by way of the Active Members assigned to that Section, shall elect by designated electronic or written ballot a Chairperson and Vice Chairperson for a term of two (2) years at a meeting held in conjunction with the Annual Meeting of the Medical Staff (or if necessary, at the first Department or Section meeting following the Annual Meeting). The Medical Staff Secretary-Treasurer will accept nominees up to thirty (30) days prior to the Annual Meeting. A list of candidates for Section Chairperson and Vice Chairperson will thereafter be transmitted to each eligible Section Member at least ten (10) days prior to the Annual Meeting (or Department meeting if required).

(b) Voting shall be by secret written ballot. A Member of the Active Staff who is eligible to vote, but who cannot be present at the Annual Meeting (or

Department or Section meeting if required), may cast an absentee ballot by designated electronic ballot pursuant to the balloting procedures set forth below. There will be a separate election for Chairperson and Vice Chairperson.

(c) In the event of a tie vote for the election of a Chairperson or Vice Chairperson, the MEC shall vote to break the tie. In the event of a tie vote at MEC, the Chief of Staff shall break the tie. In the event the Medical Staff Secretary-Treasurer receives no timely nominations for a Section Chairperson or Vice-Chairperson prior to the election, the Chief of Staff shall appoint a Member to serve in such position(s).

7.4.4. Tenure of Department and Section Chairpersons and Vice Chairpersons

Each Department and Section Chairperson and Vice Chairperson shall serve a term as set forth in his or her contractual arrangement with the System or Hospital, or if not under contract, for a two (2) year term that coincides with the Medical Staff year or until a successor is selected, unless such Chairperson or Vice Chairperson resigns sooner, is removed from office, fails to remain an eligible Member in good standing with the Department or Section (as applicable). Department and Section Chairpersons and Vice Chairpersons may serve successive terms, and there shall be no term limits.

7.4.5. Removal of Department and Section Chairpersons and Vice Chairpersons

Removal of a Chairperson or Vice Chairperson during his/her term of office may be initiated by the MEC, the Governing Board or by petition of at least twenty percent (20%) of the eligible voting Members of the Department or Section, as applicable. Such removal may be effectuated by the recommendation of a two-thirds (2/3) majority vote of all eligible voting members of the Department or Section, as applicable, voting in person or by absentee ballot, but no such removal shall be effective unless and until it has been ratified by the MEC.

7.5. Functions of Department Chairpersons and Vice Chairpersons

(a) Each Department Chairperson shall directly or through an authorized designee:

(i) Be accountable for all professional, clinical, and administrative activities within his or her Department;

(ii) Be a Member of the MEC, giving guidance on the overall medical policies of the Hospital and making specific recommendations regarding his or her own Department to assure quality patient care;

(iii) Maintain continuing review of the professional performance of all Practitioners with Clinical Privileges in his or her Department, and report regularly thereon to the Credentials Committee;

(iv) Conduct the patient care review required by the Medical Staff Bylaws and applicable policies and be responsible for the continuous assessment and improvement of the quality of care and services provided in the Department;

(v) Implement within his or her Department quality related or Peer Review activities, including but not limited to OPPE and FPPE processes, as delegated by the Governing Board or MEC, and for attendance, upon request, at meetings of the Credentials Committee;

(vi) Assist in enforcement of the Medical Staff Bylaws and applicable provisions of the Hospital Corporate Bylaws, the Hospital Corporate Compliance Plan and other Medical Staff and Hospital policies and procedures, as they pertain to his or her Department and Practitioners assigned to it;

(vii) Be responsible for implementation of Department-related actions taken by the MEC or Governing Board;

(viii) Delineate and recommend Clinical Privileges for Practitioners in his or her Department, with the assistance of Department committees where applicable, including a review of each Practitioner's quality or Peer Review record;

(ix) Be responsible for recommending to the Medical Staff the criteria for Clinical Privileges that are relevant to the patient care provided in the Department;

(x) Be responsible for the teaching, education and research programs in his or her Department;

(xi) Integrate the Department and its services into the various functions of the Hospital;

(xii) Coordinate and integrate interdepartmental and intradepartmental services;

(xiii) Preside directly or through a designee at all meetings of the Department and its committees;

(xiv) Develop and implement policies and procedures that guide and support the provision of care, treatment and services;

(xv) Assist in the determination of the qualifications and competence of Department or service personnel;

(xvi) Recommend sufficient number of qualified and competent persons to provide care, treatment and services;

(xvii) Monitor the orientation and continuing education of all Practitioners in the Department;

(xviii) Assess and recommend resources for needed patient care services;

(xix) Assist in the budgetary planning (i.e. equipment, space, sufficient number of qualified and competent individuals, etc.) pertaining to his or her Department as requested by the MEC, Hospital President or Governing Board;

(xx) Establish, as approved by the Hospital in consultation with the MEC, the Emergency Department specialty and unassigned patient call schedule consistent with Hospital and System policy and in compliance with applicable federal and State requirements; and

(xxi) Fulfill any additional functions required by Law.

(b) When undertaking the responsibilities outlined above, the Department Chairperson is acting on behalf of the Department and/or the MEC, as may be directed by the Chief of Staff.

(c) The Vice Chairperson shall perform the duties of the Chairperson in the Chairperson's absence. The Vice Chairperson shall also assist the Chairperson, as may be directed by the Chairperson, to fulfill those functions and duties set forth above.

7.6. Functions of Section Chairpersons and Vice Chairpersons

(a) Section Chairpersons shall assist the Department Chairperson to fulfill those functions and duties applicable to the Section and those Practitioners assigned to the Section. In so doing, the Section Chairperson shall be directly responsible and report to the Department Chairperson.

(b) Consistent with the foregoing, Section Chairpersons shall:

(i) Coordinate continuing education within the Section;

(ii) Coordinate, discuss, and make recommendations regarding equipment needs;

(iii) Coordinate, discuss, and make recommendations regarding criteria for Clinical Privileges applicable to the Section;

(iv) Assist to coordinate OPPE, FPPE, and other quality review applicable to Practitioners assigned to the Section;

(v) Evaluate and make recommendations concerning Applicants and Practitioners applying or reapplying for Medical Staff Membership and Clinical Privileges within the Section; and

(vi) Fulfill other functions and duties as may be required by the Bylaws, Policies, or Procedures, applicable law or accreditation standards, or as may otherwise be reasonably requested by Department Chairperson or his/her authorized designee.

(c) When undertaking the responsibilities outlined above, the Section Chairperson is acting on behalf of the Section, Department, and/or the MEC, as may be directed by the Chief of Staff.

(d) The Section Vice Chairperson shall perform the duties of the Section Chairperson in the Chairperson's absence. The Vice Chairperson shall also assist the Chairperson, as may be directed by the Chairperson, to fulfill those functions and duties set forth above.

ARTICLE VIII

STANDING MEDICAL STAFF COMMITTEES

8.1. Standing Medical Staff Committees

The standing committees of the Medical Staff shall include:

(a) The Medical Executive Committee;

(b) The Credentials Committee; and

(c) All other Standing Committees that are in Appendix A and which may be updated, as needed, in the discretion of the MEC.

All standing committees of the Medical Staff are subject to oversight by, and report to, the MEC.

8.2. Appointment and Term

Except as provided for the MEC and Credentials Committee, and unless otherwise specified in the Bylaws, Policies, and Procedures, standing Medical Staff committee members and chairpersons will be appointed by the Medical Staff Chief of Staff for a term of two (2) years, commencing on the date specified by the Medical Staff Chief of Staff.

8.3. Removal and Vacancies

Unless otherwise provided for in the Bylaws, Policies, and Procedures, the chairperson of a Medical Staff committee, with concurrence of the MEC, for good cause, may remove any Medical Staff committee member prior to the expiration of the member's term, and may fill such vacancy by appointment.

8.4. Ad Hoc Medical Staff committees

Unless otherwise provided for in the Bylaws, Policies, and Procedures, Ad Hoc Medical Staff committees, as may be required to carry out activities of the Medical Staff, may be appointed by the MEC. Such committees shall be limited to a term as established by the MEC (as applicable) and shall confine their activities and duration to the purpose for which they were appointed. The composition and duties of Ad Hoc committees, unless otherwise specified in the Bylaws, Policies, and Procedures, shall be specified by the MEC. Removal of Ad Hoc committee members may be accomplished as set forth in Section 8.3, above.

8.5. Medical Executive Committee

8.5.1. Composition

The voting members of the MEC shall be the following:

(a) Medical Staff Chief of Staff, who shall serve as the Chairperson;

(b) Medical Staff Vice Chief of Staff;

(c) Medical Staff Secretary-Treasurer; and

(d) The Chair of each Medical Staff Department

The following individuals shall serve as ex officio members of the MEC without the right to vote:

(a) Hospital President (or authorized designee);

(b) Hospital Chief Operating Officer;

(c) VPMA, when a VPMA has been appointed (or authorized designee);

(d) Vice President of Nursing;

(e) Chair of the Credentials Committee;

(f) BHS Director of Medical Staff Services (or authorized designee);

(g) BHS Director of Medical Education (or authorized designee);

(h) Program Director of the Family Medicine Residency; and

The Chairperson of the MEC may invite additional guests to MEC meetings.

8.5.2. Duties and Authority

The duties of the MEC shall be to:

(a) Serve as the final decision-making body of the Medical Staff in accordance with the Bylaws, Policies, and Procedures and to provide oversight for all Medical Staff functions;

(b) Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by the Medical Staff Bylaws;

(c) Recommend, establish, and implement, within its granted authority, policies and procedures to ensure that the needs and concerns expressed by Members of the Medical Staff, regardless of practice or location, are given due consideration;

(d) Coordinate the activities of, and to review and approve Medical Staff policies and procedures proposed by, the Medical Staff, Departments, and Sections, and their respective leadership and committees;

(e) Account to the Governing Board and to the Medical Staff for the overall quality and efficiency of professional patient care services provided in the Hospital by Practitioners, and coordinate the participation of the Medical Staff in organizational performance improvement activities;

(f) Recommend to the Governing Board all matters relating to Membership, Clinical Privileges, Medical Staff Category, Department and Section assignments, and corrective action;

(g) Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of Practitioners, including collegial and educational efforts and investigations when warranted;

(h) Make recommendations to the Hospital President and Governing Board on medico-administrative and Hospital management affairs, including patient care needs such as space, staff, and equipment;

(i) Educate the Medical Staff regarding the licensure and accreditation status of the Hospital;

(j) Address and resolve inter-Departmental/Section conflicts if ever necessary;

(k) Assign responsibility for monitoring and evaluating the quality of patient care to Departments, Sections, and Medical Staff committees, including OPPE, FPPE, investigation of concerns, implementation of actions, monitoring of results and recommending approval and revision of policies related to patient care;

(l) Review and approve the Medical Staff budget;

(m) Act upon the recommendations of the Governing Board and other Medical Staff committees;

(n) Consider, adopt and implement various policies and procedures as may be necessary to fulfill and enforce the general provisions of the Bylaws, Policies, and Procedures and the Medical Staff's overall functions and obligations;

(o) Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

(p) Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by the Bylaws, Policies, and Procedures;

(q) Review and recommend changes to the Bylaws, Policies, and Procedures as may be required;

(r) Review and approve Department, Section, and Medical Staff committee reports; and

(s) Act on behalf of the Medical Staff when the Medical Staff cannot be assembled, or between regular meetings of the Medical Staff.

Notwithstanding the establishment of Peer Review policies for implementation of various quality assurance and performance improvement activities within the Hospital, the MEC and Governing Board retain the authority at all times to undertake such Peer Review activities that they deem appropriate under the circumstances.

8.5.3. Regular Meetings

The MEC shall generally meet on a monthly basis, but in all instances will meet as frequently as needed to fulfill its functions. Regular meetings will occur at such dates, times, and places as are designated by the Medical Staff Chief of Staff or designee. Written or electronic notice stating the date, time, and place of any regular meeting shall be given to each member of the MEC at least thirty (30) days when reasonably possible.

8.5.4. Special Meetings

A special meeting of the MEC may be called by the Medical Staff Chief of Staff or designee, or by one-third (1/3) of the MEC's voting members. Written, electronic, or personal verbal notice to the members stating the date, time and place of any special meeting shall be given to each member of the MEC at least forty-eight (48) hours in advance of the special meeting, or otherwise as soon as reasonably practicable before the time of such meeting.

8.5.5. Quorum/Action

A quorum at any regular or special meeting of the MEC shall be at least fifty percent (50%) of the voting members. When permitted by the Medical Staff Chief of Staff or designee, committee action may additionally occur by mail or electronic ballot, as long as a ballot reciting the issue or resolution to be voted upon is distributed to each

committee member eligible to vote and the member is provided at least five (5) days (following the date the ballot is distributed) to consider and return the ballot by the prescribed method (unless a quorum of the committee agrees that circumstances reasonably require a more prompt response). In order for the results of a mail or electronic ballot to be binding, a majority of the votes received shall be in favor thereof.

8.5.6. Attendance Requirements

(a) Members of the MEC are expected to regularly attend meetings, but in all instances, are expected to attend at least fifty percent (50%) of regular meetings. Exceptions may be made by the Medical Staff Chief of Staff for good cause in his/her discretion. Failure to comply with this attendance requirement may constitute a good cause basis to remove a member from his/her underlying appointment giving rise to his/her membership on MEC, subject to the requirements for such removal specific to the underlying appointment.

(b) In the discretion of the Medical Staff Chief of Staff or designee, a committee may meet, or may permit any of their members to participate, in person, or by video or telephonic means such that the committee members may simultaneously interact and participate in the meeting. Notwithstanding the foregoing, when matters involving Peer Review will be discussed, in-person meetings are encouraged but are not strictly required.

8.5.7. Minutes

Minutes of each regular and special meeting of the MEC shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the Medical Staff Chief of Staff as soon as reasonably practicable after they are prepared. The MEC will maintain a permanent file of the minutes of each meeting. Minutes taken pertinent to executive sessions may be maintained, in the discretion of the Medical Staff Chief of Staff, in a separate permanent file.

8.5.8. Executive Session

The Chairperson, or at least fifty percent (50%) of the members of the MEC present at a meeting, may call for an Executive Session, at which time only voting members and those ex officio members expressly invited, may attend. All Peer Review matters should be conducted in executive session. An executive session may additionally be called to discuss personnel issues or any other sensitive issues requiring heightened confidentiality.

8.5.9. Term, Removal, and Vacancies

The members of the MEC serve by virtue of their office or other appointment, and shall therefore serve for the duration of their office or appointment. In the event such member is removed from, or otherwise vacates, his or her underlying appointment in

accordance with the Medical Staff Bylaws, that member shall automatically lose his/her membership on the MEC. Such positions shall remain vacant until the underlying appointment is filled in a manner (including interim appointments) as set forth in the Medical Staff Bylaws.

8.6. Credentials Committee

8.6.1. Composition

(a) The voting members of the Credentials Committee shall consist of at least seven (7) Members of the Active Staff. At least one of these voting members shall be the Medical Staff Secretary/Treasurer. The Chief of Staff shall also appoint one such member, who shall serve as the Credentials Committee Chairperson.

(b) The Credentials Chairperson, in consultation with the Chief of Staff, will thereafter (while serving in this role) appoint eligible Members to serve as the remaining voting members of the Credentials Committee. Each of these appointments shall be subject to MEC approval.

(c) The following individuals shall serve as ex officio members of the Credentials Committee without the right to vote: Hospital President (or authorized designee); VPMA, when a VPMA has been appointed (or authorized designee), and Director of Medical Staff Services (or authorized designee). The Chairperson of the Credentials Committee may invite additional guests to Credentials Committee meetings.

8.6.2. Term, Removal, and Vacancies

(a) Each member of the Credentials Committee shall serve for a two (2) year term subject to resignation or removal as set forth below. However, there shall be no term limits and members may serve successive terms, including but not limited to the Credentials Committee Chairperson.

(b) Members of the Credentials Committee may be removed for cause by the MEC. Any such removal shall occur in consultation with the Hospital President and VPMA (when a VPMA has been appointed). In the event such member is removed from, or otherwise vacates, membership on the Credentials Committee, the Credentials Chairperson shall appoint an alternate Member of the Active Staff to serve the remaining term. If the Credentials Chairperson is removed, then the Medical Staff Chief of Staff shall appoint an alternate Member of the Active Staff to serve the remaining term.

8.6.3. Duties and Authority

The duties of the Credentials Committee shall be to:

(a) Investigate, review, evaluate, report on, and make recommendations to the MEC regarding the qualifications of each Applicant for initial Medical Staff Membership and/or Clinical Privileges and each Practitioner for reappointment or modification of appointment to the Medical Staff and/or for Clinical Privileges and, in connection therewith, obtain and consider the recommendations of the appropriate Medical Staff Department and/or Section Chairpersons;

(b) Investigate, review, evaluate and report on matters including the clinical or ethical conduct of any Applicant or Practitioner as requested by the Medical Staff Chief of Staff or MEC;

(c) Report to the MEC on the status of pending applications, including the specific reasons for any unusual delay in processing any applications;

(d) Develop and recommend to the MEC, in consultation with Department and Section Chairpersons, processes for conducting FPPE of: (i) Practitioners that are new to the Hospital and seeking Clinical Privileges, and (ii) current Practitioners at the Hospital that have requested to receive new or additional Clinical Privileges;

(e) Develop and recommend to the MEC written processes for conducting implementation of OPPE of Practitioners at the Hospital, as well as other Peer Review activities intended to ensure the ongoing qualification of Practitioners at the Hospital;

(f) Advise the Medical Staff, and make recommendations to the MEC, on matters related to criteria and procedures for Medical Staff Membership and/or Clinical Privileges; and

(g) Fulfill those other functions designated for the Credentials Committee as set forth in the Bylaws, Policies, and Procedures and as otherwise may be required by Law.

8.6.4. Quorum/Action

A quorum at any regular or special meeting of the Credentials Committee shall be at least fifty percent (50%) of the voting members. When permitted by the Medical Staff Chief of Staff or designee, committee action may additionally occur by mail or electronic ballot, as long as a ballot reciting the issue or resolution to be voted upon is distributed to each committee member eligible to vote and the member is provided at least five (5) days (following the date the ballot is distributed) to consider and return the ballot by the prescribed method (unless a quorum of the committee agrees that circumstances reasonably require a more prompt response). In order for the results of a mail or electronic ballot to be binding, a majority of the votes received shall be in favor thereof.

8.7. Composition and Duties of Other Medical Staff Standing Committees

With the exception of the foregoing Medical Staff standing committees, the composition, duties and authority of all such committees shall be as defined by the Medical Staff Chief of Staff upon establishment of the committee, or as otherwise defined by the Bylaws, Policies, and Procedures.

8.8. Medical Staff Standing Committee Policies and Procedures

Each Medical Staff standing committee may adopt and implement various policies and procedures to fulfill its obligations and function within the Medical Staff as described herein, provided such policies and procedures do not conflict with the Bylaws, Policies, and Procedures or Law. Any standing committee policy or procedure that conflicts or is otherwise inconsistent with these conditions shall be considered void and without effect.

ARTICLE IX

MEDICAL STAFF BUSINESS MEETINGS

9.1. Regular Meeting

At least one regular Annual Meeting of the Medical Staff shall be held before the end of the Medical Staff Year each year, at which time Active Members may conduct any pertinent Medical Staff elections and may address any other pertinent issues as established by the Medical Staff Chief of Staff. The date, time, place, and manner of the Medical Staff meeting(s) shall be designated by the Medical Staff Chief of Staff and either posted in an appropriate location in the Hospital, or otherwise provided electronically or by regular mail to the eligible Members of the Medical Staff, not less than thirty (30) days prior to the meeting.

9.2. Special Meetings

The Medical Staff Chief of Staff or the MEC may call a special meeting of the Medical Staff at any time. The Medical Staff Chief of Staff shall call a special meeting within fourteen (14) days after receipt by him or her of a written request signed by not less than twenty-five percent (25%) of those Members eligible to participate and vote at such meetings, and stating the purpose of such meeting. The Medical Staff Chief of Staff or MEC (whoever called for the special meeting) shall designate the date, time and place of any special meeting. Written or electronic notice stating the date, time, and place of any special meeting of the Medical Staff shall be given to Members eligible to participate and vote at such meetings.

9.3. Quorum/Attendance

A quorum at any duly convened regular or special meeting of the Medical Staff shall consist of those present and eligible to vote, as long as at least two (2) such Members are present. In-person attendance is encouraged at all Medical Staff meetings. However, the Medical Staff Chief of Staff (or designee) or MEC may permit virtual attendance by Medical Staff Members at a regular or special meeting. Virtual attendance may be conducted through the use of any means of communication by which all attendees may simultaneously hear each other during

the meeting. Notwithstanding the foregoing, when matters involving Peer Review will be discussed, in-person meetings are encouraged and should be conducted when reasonably possible under the circumstances.

9.4. Action

An action will be approved if a majority of those attending and eligible at a meeting at which a quorum exists votes to support the action. When permitted by the Medical Staff Chief of Staff, action may alternatively occur by subsequent mail or electronic ballot, as long as a ballot reciting the issue or resolution to be voted upon is distributed to each Member eligible to vote and the Member is provided at least fifteen (15) days (following the date the ballot is distributed) to consider and return the ballot by the prescribed method. In order for the results of a mail or electronic ballot to be binding, a majority of the votes received shall be in favor thereof.

9.5. Minutes

Minutes of all Medical Staff meetings shall be taken and prepared by the Medical Staff Secretary-Treasurer, or his/her designee, and shall include a record of attendance and/or the presence of quorum and the vote taken on each matter. Copies of such minutes shall be signed by the Medical Staff Chief of Staff as soon as practicable after they are prepared and shall be forwarded to the Governing Board and the MEC. These minutes shall be deemed final when transmitted to the Governing Board, subject, however, to such corrections as may be made at the next regular or special meeting of the Medical Staff. A permanent file of the minutes of all Medical Staff meetings shall be maintained by Medical Staff Office.

ARTICLE X

MEDICAL STAFF AND DEPARTMENTAL COMMITTEE MEETINGS

Unless otherwise set forth in the Bylaws, Policies, and Procedures, the following shall apply to, and serve as default requirements of, all standing and ad hoc committees of the Medical Staff, Departments, or Sections:

10.1. Regular Meetings

Medical Staff Departments shall meet at least on a quarterly basis. Committees shall otherwise meet as often as necessary to fulfill their responsibilities and at such dates, times, and places as are designated by the chairperson of the committee. Written or electronic notice stating the date, time, and place of any regular meeting shall be given to each member of the committee.

10.2. Special Meetings

A special meeting of any Medical Staff committee or Department may be called by the chairperson, the Medical Staff Chief of Staff, or one-third (1/3) of the committee's then members (but not fewer than two (2) members). Written, oral or electronic notice stating the date, time and place of any special meeting shall be given to each committee member as soon

as practicable before the time of such meeting, unless waiver of notice is agreed to by all members of the committee.

10.3. Quorum

A quorum shall consist of those attending and eligible to vote, provided no fewer than two (2) voting Members are in attendance.

10.4. Manner of Action/Balloting Procedure

An action by a committee will be approved if a majority of those attending and eligible at a meeting at which a quorum exists votes to support the action. When permitted by the chairperson, committee action may alternatively occur by mail or electronic ballot, as long as a ballot reciting the issue or resolution to be voted upon is distributed to each committee member eligible to vote and the member is provided at least five (5) days (following the date the ballot is distributed) to consider and return the ballot by the prescribed method (unless a quorum of the committee agrees that circumstances reasonably require a more prompt response). In order for the results of a mail or electronic ballot to be binding, a majority of the votes received shall be in favor thereof.

10.5. Rights of Ex Officio Members

Ex officio members of a committee shall have all rights and privileges of regular members, except that ex officio members shall not have the right to vote and shall not be counted in determining the existence of a quorum.

10.6. Attendance

In the discretion of the chairperson, a committee may meet, or may permit any of their members to participate, in person, or by video or telephonic means such that the committee members may simultaneously interact and participate in the meeting. Regular attendance by members at meetings is expected. Notwithstanding the foregoing, when matters involving Peer Review will be discussed, in-person meetings are encouraged and should be conducted when reasonably possible under the circumstances.

10.7. Record/Minutes

Minutes or other reliable record of each regular and special meeting of a committee shall be prepared and shall identify which members were in attendance and any action taken. The chairperson shall sign such record/minutes, which shall be maintained in an appropriate file and made available to the MEC.

10.8. Executive Session

An executive session is a meeting of a committee at which only Medical Staff members who are voting members of the committee are permitted to attend, unless other individuals are expressly requested by the chairperson or committee. Executive sessions may be called by the chairperson at the request of any committee member, and shall be called by the

chairperson by duly adopted motion. An executive session may be called to discuss Peer Review issues, personnel issues, or any other sensitive issues requiring confidentiality. The Medical Staff Chief of Staff shall be an invited guest at all executive sessions.

10.9. Use of Designees

Any committee may delegate certain tasks and activities to various designees, whether a committee or individuals, including the Medical Staff Chief of Staff, Hospital President, or other Hospital personnel, to assist the committee in fulfilling its duties and responsibilities, which may include activities related to credentialing, privileging, and other Peer Review activities.

ARTICLE XI

CONFIDENTIALITY, IMMUNITY AND RELEASES

11.1. Authorizations and Conditions

(a) By applying for or exercising Medical Staff Membership and/or Clinical Privileges or by providing specified patient care services at this Hospital, each Applicant and Practitioner specifically authorizes the System, Hospital, and Medical Staff, and their authorized representatives and designees, to consult with any third party who may have information bearing on the Applicant's or Practitioner's professional qualifications, credentials, clinical competence, character, mental and physical condition, ethics, behavior, or any other matter related to the delivery of quality patient care.

(b) This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of all third parties that may be relevant to the Medical Staff and Governing Board's review, and each Applicant and Practitioner specifically authorizes all third parties to release and provide such information to the Hospital, Medical Staff, and their authorized representatives upon request, and further:

(i) Authorizes Medical Staff and Hospital representatives to solicit, release, provide, disclose, and act upon information bearing on his or her competence, professional conduct, qualifications, patient care, and quality outcomes to health care entities and their agents, including resources and entities used by the System and Hospital for internal quality control, reducing morbidity and mortality, and improving patient care;

(ii) Agrees to be bound by the provisions of this Article and to waive all legal claims against the System, Hospital, Medical Staff and any Medical Staff or Hospital representative or designee who acts in substantial compliance with the Bylaws, Policies, and Procedures;

(iii) Acknowledges that the provisions of this Article are express conditions to his or her application for or acceptance of Medical Staff Membership and/or the continuation of such Membership or to his or her exercise of Clinical Privileges at the Hospital; and

(iv) Acknowledges and consents to the System, Hospital, and Medical Staff providing any communications required or contemplated by the Medical Staff Bylaws, or otherwise deemed reasonably necessary by the Hospital or Medical Staff, by way of the email address provided by the Applicant or Practitioner to the Medical Staff Office. All Applicants and Practitioners further represent, warrant and agree that the email address they provide to the Medical Staff Office is accurate, current, private, and secure.

11.2. Confidentiality of Information

Information with respect to any Applicant or Practitioner that is submitted, collected, obtained or prepared by any System, Hospital, or Medical Staff or Peer Review Committee, or member, representative or designee of such committee, or any other health care facility or organization or Medical Staff for the purpose of achieving, maintaining and improving quality patient care, reducing morbidity and mortality, contributing to clinical research or performing any Peer Review or Peer Review Committee activity, shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than an appropriate System, Hospital, or Medical Staff representative, nor be used in any way except as provided herein or except as otherwise permitted by the Bylaws, Policies, and Procedures and by Law. Such confidentiality shall also extend to similar information that may be obtained from or provided by third parties. This confidentiality of information shall not be construed to limit the authorizations set forth in Section 11.1 above.

11.3. Immunity From Liability

There shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any act, communication, report, recommendation, or disclosure contemplated by the Bylaws, Policies, and Procedures, even where the information involved would otherwise be deemed privileged. To the fullest extent permitted by law, all individuals requesting an application, and Applicants and Practitioners requesting and/or maintaining Medical Staff Membership and/or Clinical Privileges, or any individual seeking to provide or providing patient care services in the Hospital, releases from any and all liability, extends absolute immunity and agrees not to sue, to the System, Hospital, the Medical Staff, their authorized representatives, and any third party, for any actions, omissions, communications, requests, reports, records, statements, documents, recommendations, or disclosures involving the individual, or requested, sent or received by the System, Hospital, or the Medical Staff, and their authorized representatives and designees, from or to any third party in furtherance of quality health care. The acts, communications, reports, recommendations and disclosures referred to in this Article may relate to an individual's professional qualifications, clinical competency, professional conduct, character, mental or emotional stability, physical

condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

11.4. Activities and Information Covered

The confidentiality and immunity provided by this Article shall apply to all actions, information, communications, reports, recommendations, or disclosures performed or made in connection with activities of the System, Hospital, and Medical Staff concerning, but not limited to:

- **(a)** Applications for Membership, Clinical Privileges, or other specified services;
- **(b)** Periodic reappraisals for reappointment, Clinical Privileges or specified services;
- **(c)** Patient care audits;
- **(d)** Utilization reviews;
- **(e)** FPPE and OPPE;
- **(f)** Corrective action;
- **(g)** Hearings and appellate procedures;
- **(h)** Any Peer Review or Peer Review Committee activity;
- **(i)** Reports or disclosures to the National Practitioner Data Bank, other hospitals, medical staffs, medical associations, and licensing boards;
- **(j)** System-wide quality improvement activities; and
- **(k)** Any information collected and/or reported to a Patient Safety Organization in which the System or Hospital participate.

11.5. Releases

Each Applicant and Practitioner shall additionally, upon request, execute any general or specific release as part and a condition of the Membership and/or Clinical Privileging process. Failure to execute, and thus document, such releases, however, shall in no way affect the immunity release and consents made by the Applicant or Practitioner, as described above, which are express conditions of seeking, obtaining, and/or maintaining Medical Staff Membership and/or Clinical Privileges.

11.6. Indemnification

All Medical Staff Officers, Chairpersons, Committee members, Practitioners and other individuals who are appropriately authorized by the MEC or Governing Board to act for and on behalf of the System or Hospital in performing functions pursuant to these Medical Staff Bylaws shall be indemnified by the Hospital when acting in those capacities to the fullest

extent permitted by the Bylaws, Policies, and Procedures, provided that such individuals have acted in good faith, without malice, and in the best interest of the System, Hospital, and Medical Staff.

11.7. HIPAA Compliance/Organized Health Care Arrangement

(a) As applicable, and in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Medical Staff and Hospital agree to operate as an Organized Health Care Arrangement (OHCA) under which a joint notice of privacy practices is issued, and the participating entities in the OHCA share protected health information with each other, as necessary to carry out treatment, payment, and health care operations related to activities of OHCA, such as quality assurance activities. In such case, the entities participating in the OHCA agree to abide by the terms of the joint notice with respect to protected health information created or received by a covered entity as part of its participation in the OHCA. The joint notice is written, disseminated and maintained in compliance with all applicable regulatory requirements, as outlined in the HIPAA implementing regulations.

(b) Under the OHCA, the Medical Staff and Hospital, as participants in the OHCA, separately retain all other obligations and responsibilities under the HIPAA regulations, including, but not limited to, the uses and disclosures of protected health information, fulfilling the patient rights provisions and appointment of a privacy officer. Additionally, individual Members of the Medical Staff and Hospital will retain individual liability for instances of non-compliance with the HIPAA regulations.

11.8. Reporting to Authorities

Any actions that occur as a result of or in relation to an Applicant or Practitioner that are reportable to the National Practitioner Data Bank and/or to any other pertinent state licensing board or other agency, as required or permitted by applicable state and federal law, shall be reported in the manner and time period required or permitted by such authorities.

11.9. Cumulative Effect

Provisions in these Medical Staff Bylaws and in application forms relating to authorizations, confidentiality of information and immunity from liability shall be in addition to other protections afforded by applicable state and federal laws and not in limitation thereof, and in the event of conflict, applicable law shall be controlling.

ARTICLE XII

EXCLUSIVE CONTRACTS, SERVICES, CLOSURE

As part of the ongoing process for evaluation and planning of patient care services, in the furtherance of quality patient care, the Governing Board may determine, in consultation with the MEC, that particular patient care service(s) or Clinical Privilege(s) should be implemented on an exclusive basis, pursuant to an exclusive agreement, closed, or discontinued. In the event that staffing of a patient care service or Clinical Privilege is limited or modified as referenced above, then the Membership and Clinical Privileges of impacted Practitioners, in the discretion of the Governing Board, shall be modified accordingly and/or considered a voluntary relinquishment of Medical Staff Membership and Clinical Privileges. This voluntary relinquishment, and the Governing Board's determination in connection with this Section, shall constitute an Administrative Action.

ARTICLE XIII

MEDICAL STAFF DOCUMENTS

13.1. Adoption of Related Documents

In addition to this Governance and Credentialing Manual, the Medical Staff and Governing Board have adopted the Medical Staff Corrective Action and Fair Hearing Manual. These two manuals, collectively, comprise the Medical Staff Bylaws.

13.2. Medical Staff Bylaws are NOT a Contract

The Medical Staff Bylaws are intended to create a framework to ensure compliance with pertinent State and Federal law, and accreditation requirements, and to ensure entitlement to all immunities and protections set forth in the pertinent State peer review statutes and the Federal Health Care Quality Improvement Act. These Bylaws are not intended in any fashion to create a legal contract. Accordingly, these Bylaws shall not be interpreted as, nor construed to be, a contract of any kind between the Hospital and the Medical Staff as a whole, or any individual Applicant or Practitioner individually, and shall not in any fashion give rise to any type of legal action, claim or proceeding for breach of contract.

13.3. Rules and Regulations

The MEC shall have the authority of the Medical Staff to adopt and amend the Medical Staff Rules and Regulations as may be necessary to carry out the Medical Staff's functions. Any changes to the Rules and Regulations shall become effective when approved by the Governing Board. All Rules and Regulations and amendments under consideration by the MEC must first be communicated to the Medical Staff for review and comment prior to the proposed Rules and Regulations or amendment being adopted and forwarded to the Governing Board for approval. Any Rules and Regulations adopted by the MEC and approved by the Governing Board shall be communicated to the Medical Staff in a timely manner.

Rules and Regulations may also be proposed directly to the Governing Board by a petition signed by twenty-five percent (25%) of the Members of the Active Staff. All Rules and

Regulations proposed in this manner must be presented to the MEC for review and comment before such Rules and Regulations are voted by the Active Staff. All proposed Rules and Regulations become effective only after approval by the Governing Board.

In the event there is a documented need for an urgent amendment to the Rules and Regulations to comply with a law or regulation, the MEC may provisionally adopt and the Governing Board may provisionally approve an urgent amendment without prior notice to the Medical Staff. In such case, the Medical Staff shall be promptly notified by the MEC. Members of the Medical Staff may submit any comments regarding the provisional amendment to the MEC within ten (10) days of receiving notice. The amendment will stand if there is no conflict or dispute. If twenty-five percent (25%) of the Active Staff dispute the amendment, a Joint Conference Committee shall be formed as set forth below.

13.4. Medical Staff Policies

The MEC, subject to Governing Board approval, may also adopt and amend various policies and procedures to fulfill its obligations and functions as described herein, provided such policies do not conflict with these Medical Bylaws, the Hospital Bylaws, System policies, applicable accreditation standards, or applicable Federal and State law. Any Medical Staff policy or procedure that conflicts or is otherwise inconsistent with these documents, standards, or laws shall be considered void and without effect. All policies and policy amendments adopted by the MEC and approved by the Governing Board shall be communicated to the Medical Staff in a timely manner.

Policies may also be proposed directly to the Governing Board by a majority of the Members eligible to vote at Medical Staff meetings. Before submitting to the Governing Board, policies proposed in this manner must be brought before the eligible Members by a petition signed by twenty-five percent (25%) of such Members. Any policies proposed in this manner must be presented to the MEC for review and comment before such policy is voted by the eligible Members. All proposed policies and related amendments become effective only after approval by the Governing Board.

ARTICLE XIV

CONFLICT RESOLUTION/JOINT CONFERENCE COMMITTEE

14.1. Conflict Resolution

If a conflict or dispute arises or is reasonably expected to arise between the Medical Staff and MEC regarding the adoption, amendment, or deletion of Bylaws, recommendations to adopt or change Rules and Regulations, policies, or any other issues in dispute between or among the Medical Staff, Governing Board and/or Hospital administration, the Medical Staff, the MEC, Hospital Administration, and the Governing Board should work collegially to manage the conflict or dispute. All conflict resolution should initially occur through informal steps. An informal approach may include the use of external resources or a Hospital representative trained in conflict management to help facilitate the process. If a resolution cannot be reached through informal means, the matter may be referred to a Joint Conference Committee

comprised of either the Medical Staff and Governing Board or Medical Staff and MEC, as appropriate.

If the conflict is between Members of the Medical Staff and the MEC, the disputed matter shall be submitted to a Joint Conference Committee upon a petition signed by twenty-five percent (25%) of the Members eligible to vote at Medical Staff meetings.

14.2. Joint Conference Committee

(a) **Composition**: If the conflict or dispute is between or among the Medical Staff, Governing Board, and/or Hospital Administration, the Joint Conference Committee shall consist of three (3) Members of the Governing Board and three (3) eligible Members of the Medical Staff as selected by the Chief of Staff. In such event, the Chairperson of the Joint Conference Committee shall be the Chairperson of the Governing Board.

If the conflict or dispute is between the Medical Staff and the MEC, the Joint Conference Committee shall consist of the three (3) Members of the MEC as selected by the Chief of Staff and three (3) eligible Members of the Medical Staff as designated by the eligible Member submitting the petition. In such event, the Chairperson of the Committee shall be the Chief of Staff.

The Hospital President and VPMA (when a VPMA has been appointed) shall serve as ex-officio Members of any Joint Conference Committee without vote.

(b) **Duties**: The Joint Conference Committee shall gather information regarding the conflict, meet to discuss various issues in dispute, and work in good faith to resolve the matter in a manner that protects safety and quality throughout the System, Hospital, and Medical Staff.

ARTICLE XV

POWERS AND RESPONSIBILITIES OF THE GOVERNING BOARD

As established and required by applicable state and federal law, the Governing Board serves as the final and ultimate authority in the Hospital. As such, the Governing Board is responsible for the management, operation, and control of the Hospital. In all matters, unless inconsistent with or contradictory to applicable state or federal law, the Hospital Bylaws, as well as the authority of the Governing Board will take precedence over these Medical Staff Bylaws. The procedures and processes set forth in these Bylaws shall not preclude the Board from taking any direct or independent action otherwise authorized under the Hospital Bylaws, policies, and procedures, or applicable state and federal law, including but not limited to final determinations made regarding Membership, Clinical Privileges, exclusive arrangements, and Medical Staff closure(s).

Additionally, in the event there is a documented need for an urgent amendment to the Medical Staff Bylaws to comply with a law, regulation, or accreditation standard, the Governing Board may provisionally approve an urgent amendment without prior notice to the Medical Staff. In such case, the Medical Staff shall be promptly notified by written or electronic communication by the Governing

Board. Members of the Medical Staff eligible to vote at Medical Staff meetings may submit any comments regarding the provisional amendment to the Chief of Staff within ten (10) days of receiving notice. The amendment will stand if there is no conflict or dispute. If twenty-five percent (25%) of the eligible Members dispute the amendment, a Joint Conference Committee shall be formed pursuant to Section 12.2, above.

ARTICLE XVI

MEDICAL STAFF UNIFICATION

The Hospital may elect on a future date, if it determines that such a decision is in accordance with law and regulation, to form a unified and integrated medical staff with one or more separately licensed hospitals within the System. The Hospital may only make such an election, however, if the eligible voting Members of the Medical Staff have voted to accept the proposed unification in accordance with the same process outlined in Article XVII for amending these Medical Staff Bylaws.

The formation of a unified and integrated medical staff shall additionally be contingent on the following:

(a) The unified and integrated medical staff must be established in a manner that takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital; and

(b) The unified and integrated medical staff must establish and implement policies and procedures to ensure that the needs and concerns expressed by members of the medical staff, at each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated medical staff has mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed.

In the event the Medical Staff elects to approve a unified and integrated medical staff, the Medical Staff shall retain the right to opt out of the unified and integrated medical staff. No more frequently than every two (2) years, the eligible voting Members of the Medical Staff may elect to opt-out of the unified and integrated Medical Staff in accordance with the same process outlined in Article XVII for amending these Medical Staff Bylaws (unless a different process and/or voting threshold is set forth in the medical staff bylaws of the unified and integrated medical staff).

ARTICLE XVII

AMENDMENTS TO MEDICAL STAFF BYLAWS/PRIORITY

All proposed amendments and restatements (collectively "amendments") to the Medical Staff Bylaws, should first be reviewed and recommended by the MEC. Requests for amendment may also be recommended by the Members eligible to vote at Medical Staff Business meetings following timely receipt by the Medical Staff Chief of Staff of a written petition signed by at least twenty percent (20%) of such eligible Members who are in good standing. Proposed amendments may be approved by action at regular or special meetings of the Medical Staff, or alternatively through the balloting procedure, set forth in Article IX, above. Amendments are effective when approved by the Governing

Board. Except as otherwise provided above, neither the Medical Staff nor the Governing Board may unilaterally amend these Bylaws.

In the event of a direct conflict between the Medical Staff Bylaws and any other Medical Staff Rule, Regulation or Policy, the Medical Staff Bylaws shall take priority and apply.

ARTICLE XVIII DECLARED STATE OF EMERGENCY

In the event of a Declared State of Emergency, to the extent permitted by applicable Law, the Medical Staff and Governing Board may make temporary exceptions and/or waivers to the requirements and processes contained in the Medical Staff Bylaws, Rules and Regulations, or related policy, to the extent determined to be reasonably necessary given circumstances attendant to the emergency. Any such exceptions or waivers should be reasonably documented, are temporary in nature, and should be discontinued within a reasonable timeframe upon conclusion of the Declared State of Emergency, unless earlier termination is required by Law. Waivers and exceptions initiated pursuant to this Article are in addition to other emergency and disaster related plans, procedures, and exceptions that may be available to the Hospital or Medical Staff, either pursuant to these Bylaws or otherwise, and shall not constitute a violation of the Bylaws, Policies, and Procedures.

ARTICLE XIX PARLIAMENTARY PROCEDURE

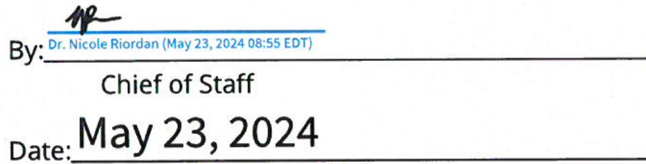
Any procedural matter not clarified in the Medical Staff Bylaws shall be evaluated and acted upon by the Medical Staff Officers or Chairperson, as appropriate, in conjunction with either the Standard Code of Parliamentary Procedure or Robert's Rules of Order, whichever has been adopted by the Medical Staff.

ARTICLE XX ADOPTION

The Medical Staff Bylaws, excluding the Medical Staff Rules and Regulations, shall be adopted at any regular or special meeting of the Active Staff, and shall replace any previous Medical Staff Bylaws, and shall become effective immediately upon approval by the Governing Board.

20.1 Medical Staff

This Governance and Credentialing Manual, as amended and restated, was recommended to the Governing Board by the Medical Staff and adopted by the Governing Board in accordance with and subject to the Medical Staff Bylaws.



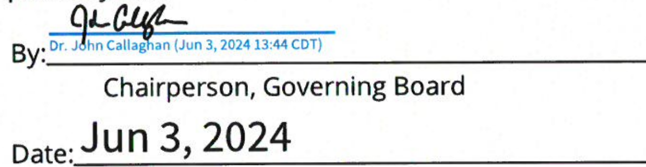
By:______________________

Chief of Staff

Date: May 23, 2024

20.2 Governing Board

This Governance and Credentialing Manual, as amended and restated, was approved and adopted by consent of resolution of the Governing Board after considering the Medical Staff's recommendation and in accordance with and subject to the Hospital's Bylaws.



By:______________________

Chairperson, Governing Board

Date: Jun 3, 2024

20.3 Record of Revisions

Date	Article/Section Modified

APPENDIX A

MEDICAL STAFF ORGANIZATIONAL PLAN

The Medical Executive Committee has approved the following committees, which serve as Medical Staff Standing Committees. All such committees are hereby constituted as Peer Review Committees to the extent they are engaged in lawful Peer Review activities.

Unless otherwise specified below, the Chief of Staff shall appoint an eligible member to serve as the Committee's chairperson. Thereafter, the Committee's chairperson (in consultation with the Chief of Staff) shall appoint eligible members to serve as voting and non-voting members of the Committee (except for those members, as identified below, who serve by virtue of their position). All committee appointments are subject to MEC approval.

ARTICLE I

AIR/MEDICAL TRANSPORT COMMITTEE

1.1. Purpose and Meetings

The purpose of the Air Medical Transport Committee is to oversee the operation of and address issues related to Memorial's Air Medical transport program, Memorial MedFlight, and Memorial's transfer system, TransferDirect. The Committee shall meet as necessary, not less than quarterly, and shall maintain a permanent record of its proceedings and actions, and report to the MEC.

1.2. Composition

The Air/Medical Transport Committee includes at least ten (10) Members of the Medical Staff representing as many as possible of the following specialties: emergency medicine, cardiothoracic surgery, obstetrics/gynecology, pediatrics (PICU), orthopedic surgery, general surgery/trauma, cardiology, neurosurgery, medicine, and critical care medicine. Additional non-voting members may include the MedFlight Program Manager, Trauma Services Director, Outreach Transport Coordinator, Transfer Coordinator, Administrative Vice President, and other healthcare professionals who can contribute specialized or unique knowledge and skills.

1.3. Function

1.3.1. Review and revision of standing medical orders and other protocols for Memorial MedFlight helicopter personnel.

1.3.2. Development and oversight of transfer coordination procedures, including review of transfer conversations, between referral sources and Memorial Hospital.

1.3.3. Ongoing review of care provided to patients transported by Memorial MedFlight.

ARTICLE II

BYLAWS COMMITTEE

2.1. Purpose and Meetings

The Bylaws Committee fulfills Medical Staff responsibilities related to review and revision of the Medical Staff Bylaws, the Related Manuals, the Rules and Regulations, the Policy Manuals, and any forms promulgated in connection with these documents. It also assumes the responsibility for investigating and providing recommendations on such Administrative policy-making and planning matters and activities of concern to the Staff as are referred by the MEC. It also supervises overall Medical Staff compliance with accreditation and other regulatory requirements applicable to the Medical Staff or any of its clinical units. The Committee shall meet as necessary, not less than annually, and shall maintain a permanent record of its proceedings and actions, and report to the MEC.

2.2. Composition

The Bylaws Committee includes at least three (3) Members of the Medical Staff. A representative of Administration serves without a vote.

2.3. Function

The Bylaws Committee conducts, on a periodic basis (no less than once every three (3) years), a review and revision of the Medical Staff Bylaws, the Related Manuals, the Rules and Regulations, the Policy Manuals, and any forms promulgated in connection with these documents. These review activities are undertaken both as a good governance practice and in order to assist the MEC in fulfilling the document review responsibilities that are established in the Bylaws.

ARTICLE III

INFECTION PREVENTION COMMITTEE

3.1. Purpose and Meetings

The Infection Prevention Committee reviews infection reports and investigates causes of Hospital infections and makes recommendations concerning the prevention and proper isolation of infectious diseases. The Committee shall meet as necessary, not less than quarterly, and shall maintain a permanent record of its proceedings and actions, and report to the MEC. The Committee submits any findings of significant variances to the MEC and, where appropriate, to the Medical Staff Peer Review Committee.

3.2. Composition

Suggested membership includes at least five (5) Members of the Medical Staff from (minimally) the Departments of Surgery, Medicine, and Pediatrics. Representatives from Nursing Services, Administration, and other appropriate Hospital departments may serve without vote.

3.3. Function

3.3.1. Maintain surveillance over the Hospital Infection Control Program.

3.3.2. Develop a system for reporting, identifying, and analyzing the incidence and cause of infections.

3.3.3. Develop and implement a preventive and corrective program that is designed to minimize infection hazards, including establishing, reviewing, and evaluating aseptic isolation and sanitation techniques.

3.3.4. Develop, evaluate, and review preventive, surveillance, and control policies and procedures relating to all phases of the Hospital's activities, including:

(a) Operating Rooms

(b) Delivery Rooms

(c) Special Care Units

(d) Central Sterile Processing

(e) Isolation procedures

(f) Prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment

(g) Testing of Hospital personnel for carrier status

(h) Disposal of infectious materials

(i) Environmental Services and Laundry sterilization and disinfection procedures by heat, chemicals, or otherwise

(j) Food sanitation and waste management

(k) Other situations as required.

3.3.5. Coordinate activities with the Pharmacy and Therapeutics Committee.

3.3.6. Conduct on a periodic basis, statistical studies of antibiotic usage and susceptibility/resistance trend studies in conjunction with the Pharmacy and Therapeutics Committee.

ARTICLE IV

INTENSIVE CARE UNIT (ICU) COMMITTEE

4.1. Purpose and Meetings

The purpose of the ICU Committee is to promote competent and quality medical care by developing policies, procedures, clinical guidelines, and clinical protocols (including special techniques, therapeutic agents, specialized training, equipment, etc.) related to the clinical activities of the Special Care Units. The Committee shall meet as necessary, not less than quarterly, and shall maintain a permanent record of its proceedings and actions, and report to the MEC.

4.2. Composition

The ICU Committee shall include at least seven (7) Members of the Medical Staff. The composition of the committee should include multi-disciplinary representation from different Medical Staff Departments, but shall minimally include a pulmonologist and an intensivist. A representative from Administration, Quality Management, and applicable hospital departments may serve without vote.

4.3. Function

4.3.1. Developing and enforcing policies and procedures for the activities of the Special Care Units: ICU, CCU, OHR, and medical and cardiac step down units.

4.3.2. Establishes guidelines for the use of special techniques and therapeutic agents, establishes criteria and guidelines for admission and discharge of patients in these units, and establishes guidelines concerning quality of care.

4.3.3. Involved in special training, protocols, equipment needs of the units, and establishes guidelines for the activities of health care personnel.

ARTICLE V

MEDICAL STAFF PEER REVIEW COMMITTEE

5.1. Purpose and Meetings

The Medical Staff Peer Review Committee ("PRC") serves as the Medical Staff's multi-disciplinary peer review committee. The PRC shall meet as necessary, not less than quarterly, and shall maintain a permanent record of its proceedings and actions, and report to the MEC.

5.2. Composition

The PRC includes at least five (5) Practitioners appointed by the Medical Staff Chief of Staff. The Chief of Staff should endeavor to include representatives of different medical specialties when appointing the PRC's members. The current elected Vice Chief of Staff shall also serve as a standing member of the Committee. The Vice President for Medical Affairs, acting as an Administrative representative, and Quality Manager also attend without vote.

5.3. Function

The PRC has oversight of the Medical Staff's routine Peer Review process as delegated by the MEC to the PRC. Accordingly, the PRC coordinates and monitors the Medical Staff data gathering and analysis components of the Medical Staff's Peer Review program and conducts FPPE in relation to clinical and professional conduct concerns when such focused evaluation is triggered and/or such matters are otherwise referred to the PRC for review. In the event the PRC determines that adverse action may be required, the PRC refers such matters to the MEC as set forth in the Corrective Action and Fair Hearing Manual. The PRC will regularly report to the MEC regarding its activities and relevant findings. Additional PRC functions may be set forth in the prevailing Medical Staff Peer Review Policy, which is incorporated herein by reference.

ARTICLE VI

ONCOLOGY CARE COMMITTEE

6.1. Purpose and Meetings

The purpose of the Oncology Care Committee is to provide advice, consultation, and direction for the Oncology Unit, to engender a holistic approach to patient care by the establishment of a multi-disciplinary team, and to determine needs for educational programs which will enable the provision of comprehensive care to the patient. The Committee shall meet as necessary, not less than quarterly, and shall maintain a permanent record of its proceedings and actions, and report to the MEC on policies and procedures that affect Medical Staff Members or Privilege holders.

6.2. Composition

The Oncology Care Committee shall include at least five (5) Members of the Medical Staff. The composition of the committee should include representation from applicable medical specialties, but shall minimally include a medical oncologist. The Committee may also include without vote, the Cancer Program Administrator and representatives from the following: Radiation Oncology, Breast Care Center, Pain Center, Lymphedema program, Pediatric Oncology, Clinical Research, Oncology Nursing, Social Services, Quality Management, community representation, and a Certified Tumor Registrar (CTR).

6.2.1. To establish and review Oncology Unit policies and procedures, for the provision of cancer care;

6.2.2. Make recommendations regarding Oncology Unit performance and efficiencies;

6.2.3. Provide guidance on clinical, technological, quality issues, and new program development;

6.2.4. Provide a forum for physician input and feedback; and

6.2.5. Make recommendations to PRC and/or MEC, as applicable, related to interpersonal conflict and disruptive behavior.

ARTICLE VII

OPERATING ROOM COMMITTEE

7.1. Purpose and Meetings

The purpose of the Operating Room Committee is to address issues regarding operating room policies and procedures and to provide guidance on clinical, technological, and quality issues, and to provide input on new program development. The Committee shall meet as necessary, not less than quarterly, and shall maintain a permanent record of its proceedings and actions, and report to the MEC.

7.2. Composition

The Operating Room Committee shall be composed of nine (9) to ten (10) eligible voting members. Membership may include representation from the following specialties: anesthesiology, obstetrics-gynecology, ophthalmology, orthopedic surgery, otolaryngology, pathology, radiology, general surgery, neurosurgery, plastic surgery, cardiothoracic surgery, and urology. Additional non-voting members include the Executive Director of Surgical Services, Director of Outpatient Surgery, and the Directors of Major Surgery.

7.3. Function

7.3.1. Review operating room policies and procedures;

7.3.2. Review OR time allocations/blocks;

7.3.3. Make recommendations regarding OR performance and efficiencies;

7.3.4. Provide guidance on clinical, technological, quality issues, and new program development;

7.3.5. Provide a forum for physician input and feedback; and

7.3.6. Make recommendations to PRC and/or MEC, as applicable, related to interpersonal conflict and disruptive behavior**.**

ARTICLE VIII

PHARMACY AND THERAPEUTICS COMMITTEE

8.1. Purpose And Meetings

The purpose of the Pharmacy and Therapeutics Committee is to promote and maximize rational drug use within the Hospital. This purpose is both advisory and educational in nature. In an advisory capacity, the Committee recommends the adoption of, or assists in the formulation of, policies regarding the evaluation, selection, and therapeutic use of drugs in the Hospital. In an educational capacity, the Committee recommends or assists in the

formulation of programs designed to meet the needs of the professional staff (physicians, nurses, pharmacists, and other healthcare practitioners) for complete and current knowledge on matters related to drugs and drug use. The Committee shall meet as necessary, not less than quarterly, and shall maintain a permanent record of its proceedings and actions, and report to the MEC.

8.2. Composition

The Committee is comprised of at least five (5) Members of the Medical Staff representing various Departments. Additional non-voting members may include the Director of Pharmacy, Director of Nursing, Administrative Vice President, and other healthcare professionals who can contribute specialized or unique knowledge and skills.

8.3. Function

8.3.1. Advise the Medical Staff and Hospital administration in matters pertaining to the use of drugs;

8.3.2. Advise pharmacy on the implementation of effective drug distribution and control procedures;

8.3.3. Maintain a formulary system, whereby a formulary of drugs accepted for use in the Hospital is compiled and continually revised. The Committee will define operating policies and procedures for the formulary system including those governing generic substitution, therapeutic interchange, and investigational drugs. These policies and procedures will be made available to, and observed by all Staff Members;

8.3.4. Establish programs and procedures which help ensure cost effective drug therapy;

8.3.5. Participate in performance improvement activities related to the prescription, distribution, and administration of drugs;

8.3.6. Direct drug usage evaluation studies, review the results of such activities, and initiate any necessary follow-up action;

8.3.7. Establish educational programs for the Hospital's professional staff on matters related to drug therapy;

8.3.8. Review adverse drug reactions occurring in the Hospital; and

8.3.9. Make recommendations concerning drugs to be stocked in Hospital patient care areas.

ARTICLE IX

PHYSICIAN ASSISTANCE COMMITTEE

9.1. Purpose And Meetings

The purpose of the Physician Assistance Committee is to serve as the Medical Staff's committee resource in relation to Medical Staff wellness and impairment matters and concerns. The Committee shall meet as necessary, not less than annually, and shall maintain a permanent record of its proceedings and actions, and report to the MEC.

9.2. Composition

The Committee is comprised of at least five (5) Members of the Medical Staff representing various Medical Staff Departments. Additional non-voting members may include the Vice President for Medical Affairs and other healthcare professionals who can contribute specialized or unique knowledge and skills.

9.3. Function:

9.3.1 To provide a service that can be performed for Practitioners by their colleagues, by recognizing and encouraging Practitioners who may be impaired and unfit for duty as a result of physical, psychiatric, or emotional illness, or as the result of alcohol or drug use, to submit themselves voluntarily to a peer review committee thereby negating the requirement of direct reporting to the Medical Licensing Board.

9.3.2 To define the process for times when the situation ultimately deteriorates to the point of becoming a threat to patient care, and formal reporting to the Hospital Board is required, as well as the initiation of Corrective Action under the Medical Staff Bylaws, and, in the case of a Practitioner who is an employee of the Hospital, the Hospital's employee disciplinary action policies.

9.3.3 To assist an individual Practitioner in active medical practice who had previously functioned in a competent and productive fashion and who has demonstrated behaviors that suggest impairment and inadequacy in his function as a Practitioner.

9.3.4 To identify and manage matters of individual physician health which are separate from the medical staff disciplinary function.

9.3.5 To provide education about Practitioner health, as well as the prevention of physical, psychiatric, or emotional illness and facilitate confidential diagnosis, treatment and rehabilitation of Practitioners who suffer from a potentially impairing condition.

9.3.6 To assist and rehabilitate rather than discipline.

9.3.7 To aid a Practitioner in retaining or regaining optimal professional functioning, consistent with protection of patients.

9.3.8 To otherwise fulfill those functions and facilitate those processes contained in the pertinent Bylaws, Policies, and Procedures.

ARTICLE X

TRAUMA COMMITTEE

10.1. Purpose And Meetings

The purpose of the Trauma Committee is to monitor and evaluate the quality, timeliness, and appropriateness of trauma care and to resolve any identified problems. The Committee shall meet as necessary, not less than quarterly, and shall maintain a permanent record of its proceedings and actions, and report to the MEC.

10.2. Composition

The voting membership of the committee includes at least eight (8) Members of the Medical Staff from the Departments of Surgery, Anesthesia, Radiology, Emergency Medicine, Family Medicine, Otolaryngology, Orthopedics, Pathology, and Pediatrics. Also suggested is a thoracic surgeon and a neurosurgeon. Non-voting members may include the Emergency Department Nursing Director, the Trauma Clinical Nurse Specialist, and representatives from Quality Management and Administration.

10.3. Function

11.3.1 Review trauma cases according to quality care criteria.

11.3.2 Coordinate the functions of the multidisciplinary response team.

11.3.3 Review and evaluate pre-hospital trauma care.

11.3.4 Make recommendations regarding hospital support services including Radiology, Laboratory, Blood Bank, and Central Sterile Processing.

11.3.5 Collect and evaluate trauma data and make recommendations for changes in trauma care as appropriate.

11.3.6 Report findings to the appropriate Department, PRC, Quality Assessment Committee and/or MEC.

ARTICLE XI

UTILIZATION MANAGEMENT COMMITTEE

11.1. Purpose and Meetings

The purpose of the Utilization Management Committee ("UMC"), which serves as the Medical Staff's utilization review committee, is to provide recommendations on utilization programs, processes and guidelines. It is responsible for internal monitoring and reporting on cost and efficiency, promoting care coordination, and cost reduction. The Committee in all of its functions, is a Peer Review Committee and submits any findings of significant variances to the MEC and, where appropriate, to the Medical Staff Peer Review

Committee. The Committee shall meet as necessary, not less than quarterly, and shall maintain a permanent record of its proceedings and actions, and report to the MEC.

11.2. Composition

The UMC shall consist of members of the Active Staff with at least one representative from the departments of Emergency Medicine, Medicine, Family Medicine, Surgery, Psychiatry, Pediatrics, and Radiology. Non-voting ad hoc members should be from Administration, Case Management, Nursing, and Quality Improvement. Additional provisions related to composition may be set forth in the Hospital's prevailing Utilization Management Plan, which is incorporated herein by reference.

11.3. Function

11.3.1 Utilization Management Plan. The Committee shall formulate a written utilization management plan for the Hospital. Such plan, as approved by the Executive Committee of the Medical Staff, the Medical Staff, the President and the Board, must be in effect at all times and must include all of the following elements:

(a) the methods to be used in selecting cases on a sample or other basis;

(b) the definition of what constitutes the period of extended duration;

(c) the relationship of the utilization review plan to claims administration by a third party;

(d) the responsibilities of the Hospital's administrative staff in support of utilization review; and

(e) any other elements deemed necessary or appropriate in order to satisfy those utilization review functions required by Law.

11.3.2 The Committee shall perform its utilization review functions in compliance with the Utilization Management Plan and as may otherwise be required by Law.