REHABILITATION HOSPITAL OF FORT WAYNE
FORT WAYNE, INDIANA

MEDICAL STAFF BYLAWS

ADOPTED BY MEDICAL STAFF
November 2, 2015

ADOPTED BY BOARD OF TRUSTEES
November 8, 2015

REHABILITATION HOSPITAL
MEDICAL STAFF BYLAWS
INDEX

MEDICAL STAFF BYLAWS

OF

REHABILITATION HOSPITAL

P R E A M B L E

WHEREAS, Rehabilitation Hospital of Fort Wayne, hereinafter referred to as "Hospital", is operated by IOM Health Systems, L.P. hereinafter referred to as "Corporation", a private corporation organized under the laws of the state of Indiana and is lawfully doing business in Indiana, and is not an agency or instrumentality of any state, county or federal government; and

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

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

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

WHEREAS, the Medical Staff must cooperate with and will accept the direction of the Board of Trustees; and

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

NOW, THEREFORE, the practitioners practicing in Rehabilitation Hospital of Fort Wayne hereby organize themselves into a Medical Staff conforming to these bylaws.

D E F I N I T I O N S

"Active Staff" means those Medical Staff members who have declared the Hospital to be their primary hospital for the practice of medicine and other related hospital activities, and who have been recognized by the Medical Staff by formal review processes to be members in good standing clinically and in all other ways referred to in these Bylaws

"Adverse Recommendation" or "Adverse Action" means any recommendation or action which would materially restrict or deny the privileges or membership of a practitioner as defined in the Fair Hearing Plan contained in Appendix "A".

"Allied Health Professional" or "AHP" means any credentialed individual, other than a practitioner, who performs special examinations or treatments or renders other services under the direction and supervision of the member of the Medical Staff who employs/sponsors and takes responsibility for him/her.

"Board" means the Board of Trustees of the Rehabilitation Hospital.

"Chief Executive Officer" or "CEO" means the individual appointed by the Corporation based on recommendations from the Board of Trustees to provide for the overall management of the Hospital.

"Clinical Privileges" means the Board's recognition of practitioners' or AHPs' competence and qualifications to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services.

"Clinical Service" means a unit of the Medical Staff, comprised of practitioners who have been granted membership in that service.

"Consulting Staff" means those practitioners who possess specialized skills needed at the Hospital for a specified project or on an occasional basis when requested by authorized staff officials.

"Contract Practitioner" means a practitioner who is or will be providing professional medical services to the Hospital and/or its patients pursuant to a direct contract with the Hospital. Such a practitioner may or may not be an employee of the Hospital, but shall in either event be required to fulfill the requirements of the Staff category to which he is assigned.

"Corporation" means IOM Health Systems, L.P.

"Corrective Action" means any action taken against a member of the Medical Staff by the Board and/or the Chief Executive Officer in response to conduct by such member which is detrimental to patient care, detrimental to the best interests of the Hospital, in violation of these Bylaws or any rule or regulation promulgated pursuant hereto or any law or regulation applicable to such member's practice. The recommendation or confirmation of corrective action may entitle the affected member to the appellate review procedures provided for in these Bylaws if membership or clinical privileges are materially limited.

"Courtesy Staff" means those Medical Staff members who do not intend to use the Hospital as their primary hospital for practicing medicine, but who upon occasion, because of their association with Active Staff members and/or place of practice, need access to the Hospital to accommodate their patients and colleagues.

"Credentials Advisor" means a Medical Staff member appointed by the Medical Executive Committee who shall serve as Credentials Committee Advisor and act on behalf of the Credentials Committee;

"Credentials Committee" which shall be responsible for reviewing applications for appointment and reappointment to the Medical Staff and AHP Staff, matters of membership or clinical privileges, and matters of corrective action, all pursuant to these Bylaws.

"Data Bank" means the National Practitioner Data Bank (or any state designee thereof) established pursuant to the Health Care Quality Improvement Act of 1986, for the purposes of reporting of adverse actions and Medical Staff malpractice information.

"Days" Unless otherwise specified, any reference to number of days refers to calendar days.

"Designee" means one selected by the CEO or other officer to act on his/her behalf with regard to a particular responsibility or activity as permitted by these bylaws.

"Ex Officio" means by virtue of an office or position held. Unless otherwise expressly provided, an ex officio committee member shall not have full voting rights.

"Fair Hearing Plan" means the procedure adopted by the Medical Staff with the approval of the Board to provide for an evidentiary hearing and appeals procedure when a physician's clinical privileges are adversely affected by a determination based on the physician's professional conduct or competence. The Fair Hearing Plan is incorporated into these Bylaws and is contained in Appendix "A" hereto.

"Honorary Staff" means those former Medical Staff members who have retired from the Medical Staff and whom the Staff wishes to honor in recognition of their service to the Hospital or other noteworthy contributions to its activities, and other practitioners of outstanding professional attainment. Unless otherwise specified, Honorary Staff members shall neither enjoy the privileges, prerogatives or rights nor be subject to the qualifications, obligations or requirements otherwise applicable to Medical Staff members.

"Hospital" means Rehabilitation Hospital.

"Licensed Independent Practitioner" means any individual permitted by law and by the Medical Staff and Board to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

"**Medical Director**" means the physician appointed by the Chief Executive Officer or his designee, through contractual agreement, to oversee the decision-making process for admission and continued stay of those served. The Medical Director also assists the Medical Staff leadership in carrying out its duties.

"Medical Executive Committee" or "MEC" means the Executive Committee of the Medical Staff. The Medical Executive Committee is empowered to act for the Medical Staff as a whole in all matters except as noted in these Bylaws.

"Medical Staff" means all practitioners who have been granted Medical Staff membership and privileges to attend patients in the Hospital.

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

"Medical Staff Year" means January 1 through December 31.

"Member" means a practitioner who has been granted Medical Staff membership and privileges pursuant to these bylaws.

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

"Personnel of a Peer Review Committee" means not only members of such committee but also all of the committee's employees, representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves on a peer review committee in any capacity whether such person is acting as a member or is under a contract or other formal agreement with the committee, and any person who participates with or assists the committee with respect to its actions.

"Practitioner" means a doctor of medicine, doctor of osteopathy, or doctor of podiatry possessing an unlimited license to practice in the state of Indiana, or a duly licensed doctor of dentistry.

"President", "President Elect" and "Vice President" mean the duly elected and authorized President, President Elect and Vice President of the Medical Staff. The Medical Staff President also serves as the Medical Executive Committee Chairman. The Medical Staff President acts as the liaison between the Hospital's administration and the Medical Staff and assists the Medical Staff Leadership in carrying out its duties.

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

"Professional Review Action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician.

"Professional Review Committee" or "Peer Review Committee" means the governing body or any committee of the governing body, any committee of the Medical Staff, and any service, section, or committee of the Medical Staff which conducts professional review activity. Such committees and all personnel of such peer review committees or professional review committees shall and hereby do claim all privileges and immunities afforded to them by the Federal Health Care Quality Improvement Act of 1986 and the Indiana Peer Review Act as these may hereafter be amended.

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

"Telemedicine" means the use of electronic communication or other communication technologies to provide or support clinical care at a location remote from Hospital.

Gender nouns and pronouns are used throughout these Bylaws for ease of reading and are not intended to exclude members of the opposite sex.

ARTICLE I
NAME

The name of this organization shall be the Medical Staff of Rehabilitation Hospital of Fort Wayne.

ARTICLE II
PURPOSES & RESPONSIBILITIES

2.1 PURPOSE

The purposes of the Medical Staff are:

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

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

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

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

2.1(e) To work with the Board and management to develop a strategy to maintain medical costs within reasonable bounds and meet evolving regulatory requirements;

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

2.1(g) To promulgate, maintain and enforce bylaws and rules and regulations for the proper functioning of the Medical Staff;

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

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

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

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

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff include:

2.2(a) Ensuring that practitioners and AHPs cooperate with each other in caring for patients in the Hospital;

2.2(b) Accounting for the quality, appropriateness and cost effectiveness of patient care rendered by all practitioners and AHPs authorized to practice in the Hospital, by taking action to:

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

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

(3) Implement a utilization review program, based on the requirements of the Hospital's Utilization Review Plan;

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

(5) Initiate and pursue corrective action with respect to practitioners and AHPs, when warranted;

(6) Develop, administer and enforce these bylaws, the rules and regulations of the staff and other hospital policies related to medical care;

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

(8) Ensure that the functions delineated in Article 13.1 of these Bylaws are performed by appropriate standing or ad hoc committee of the Medical Staff; and

(9) Implement a process to identify and manage matters of individual physician health that is separate from the Medical Staff disciplinary function in accordance with the Impaired Physician Policy, which is incorporated herein and attached as Appendix “B” hereto.

2.2(c) Assisting the Board in maintaining the accreditation status of the Hospital;

2.2(d) Participating and cooperating in implementation of the policies of federal and state regulatory agencies, including the requirements of the Data Bank; and

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

2.3 PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT

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

ARTICLE III
MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Medical Staff membership is a privilege extended by the Hospital, and is not a right of any person. Membership on the Medical Staff or the exercise of temporary privileges shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these bylaws. Membership on the Medical Staff shall confer on the practitioner only such clinical privileges and prerogatives as have been granted by the Board in accordance with these bylaws. No person shall admit patients to, or provide services to patients in the Hospital, unless he/she is a member of the Medical Staff with appropriate privileges, or has been granted temporary, one-case, locum tenens, or proctoring privileges as provided herein.

3.2 BASIC QUALIFICATIONS/CONDITIONS OF STAFF MEMBERSHIP

3.2(a) Basic Qualifications

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

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

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

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

(4) Have professional liability insurance that meets the requirements of Article 15.4;

(5) Are graduates of an approved college holding appropriate degrees;

(6) Have successfully completed an approved residency and/or fellowship program or the equivalent where applicable;

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

(8) New applicants (with the exception of dentists and RediMed physicians) must be board certified or board qualified. To be regarded as “qualified”, the applicant shall have recently completed an accredited residency and/or fellowship training program. Board certification shall be by ABMS or AOA approved member boards or for podiatrists by the ABPS or ABPOPPM. He/she must achieve board certification within the time period prescribed by the relevant board, but no longer than five years following appointment to the Medical Staff.

If board certification is not obtained within the required time period, the physician shall no longer satisfy the requirements of this section, and the physician shall not be reappointed as a member of the Medical Staff. In addition, all members of the Medical Staff must maintain board certification to be eligible for reappointment. It is the expectation of Rehabilitation Hospital that recertification will be accomplished prior to expiration. If, however, a physician has not completed all steps in his/her board recertification process at the time of reappointment, a "grace period" may be applied to extend membership and privileges for an interval not to exceed one year. The duration of such "grace period" shall be determined on an individual basis by the MEC and shall be based specifically on the nature of the deficiency. The practitioner shall be responsible to provide all information necessary for the committee to make a determination about the suitability of a grace period and the duration of said period at least four months in advance of his/her reappointment date.

The above requirement shall not apply to any practitioner already a member of the Medical Staff, and not certified, as of September 16, 2003.

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

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

3.2(b) Effects of Other Affiliations

No person shall be automatically entitled to membership on the Medical Staff or to exercise the particular clinical privileges merely because he/she is licensed to practice in this or any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical board.

3.2(c) Non-Discrimination

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

3.2(d) Ethics

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

3.3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each member of the Medical Staff shall:

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

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

3.3(c) Abide by the Medical Staff Bylaws and other lawful standards, policies (including Impaired Physician and Code of Conduct, Appendices "B" and "C" hereto), and Rules & Regulations of the Medical Staff;

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

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

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

3.3(g) Be encouraged to be a member in good standing of respective professional societies and to participate in educational programs as contemplated by these bylaws;

3.3(h) Pay membership dues and other assessments as established by the MEC;

3.3(i) Satisfy the continuing education requirements established by the Medical Staff and/or clinical services;

3.3(j) Attest that he/she suffers from no physical or mental health condition which could affect ability to perform the functions of Medical Staff membership and exercise the privileges requested prior to initial exercise of privileges;

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

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

3.3(m) Refrain from engaging in business practices which are predatory or harmful to the Hospital or the community;

3.3(n) Must notify the Medical Staff Office and Medical Staff President within seven (7) days if:

(1) His/Her professional licensure in any state is suspended or revoked, or if any investigation, sanction or notice of intent to sanction or to revoke, suspend or modify his/her license;

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

(3) Any criminal charges, other than minor traffic violations, are brought/initiated against him/her and any guilty pleas or convictions entered; and

(4) He/she has been excluded, debarred, suspended, or otherwise declared ineligible from any federal or state health care or procurement program, including Medicare and Medicaid, has been convicted of a crime that meets the criteria for mandatory exclusion, debarment, suspension or ineligibility from such programs, or is under investigation by any such program.

Must notify the Medical Staff Office and Medical Staff President within thirty (30) days if:

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

(6) He/she is currently either voluntarily or involuntarily participating in any rehabilitation or impairment program, or has ceased participation in such a program without successful completion; and/or

(7) There has been involuntary limitation, reduction or loss of clinical privileges on any Medical Staff (including relinquishment of such medical staff membership or clinical privileges after an investigation of competence, professional conduct, or patient care activities has commenced or to avoid such investigation; or receipt of sanction or notice of intent to sanction from any peer review or professional review body).

Failure to provide any such notice, as required above, may result in immediate loss of medical staff membership and clinical privileges, without right of fair hearing procedures, as determined by the MEC.

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

3.3(p) Admission History and Physical

Each patient admitted for inpatient care shall have a complete comprehensive admission history and physical examination recorded by a qualified physician (or other licensed practitioner who has been credentialed and granted privileges to perform a history and physical examination) within twenty-four (24) hours of admission. A written admission note shall be entered at the time of admission, documenting the diagnosis and reason for admission. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the history and physical shall specifically document the circumstances surrounding the need for additional post-acute care. Should the physician fail to ensure that the patient's history and physical is dictated in time to be transcribed and on the chart within twenty-four (24) hours after admission, the record shall be considered delinquent and the Medical Staff President or his/her designee or the CEO or his/her designee may take appropriate steps to enforce compliance. If the history and physical is completed by a licensed independent practitioner who is not a physician, the findings, conclusions and assessment of risk must be endorsed by a qualified physician prior to any invasive diagnostic or therapeutic interventions, or other procedures.

Minimum Content:

The history and physical shall contain the following information:

1. Date of examination
2. Primary rehab diagnosis
3. Medical history, including the chief complaint

4. Details of the present illness
5. Relevant past, social, and family histories (appropriate to the patient's age)
6. Current medications and allergies
7. Inventory/review of each body system, as appropriate
8. A summary of the patient's psychosocial needs, as appropriate to the patient's age and reason for hospitalization
9. A report of relevant physical examinations. The physical exam, at a minimum, must address the heart, lungs, and neurological or mental status.
10. Current functional status
11. Potential risk factors
12. A statement of the conclusions or impressions drawn from the admission history and physical examination (provisional or admitting diagnosis(es).
13. Rehabilitation plan
14. Rehabilitation outcome goals and interventions
15. Post Admission Physical Evaluation

A history and physical performed within thirty (7) days prior to hospital admission may be used, as long as the medical record contains durable, legible practitioner documentation indicating the H&P was reviewed and the patient was examined, and noting any changes in the patient's condition not consistent or otherwise reflected in the H&P. If there have been any changes in the patient's condition that are not consistent with or noted in the history and physical, those must be documented within twenty-four (24) hours of admission.

3.4 DURATION OF APPOINTMENT

3.4(a) Duration of Initial Appointments

All initial appointments to the Medical Staff shall be for a period not to exceed two (2) years. In no case shall the Board take action on an application, refuse to renew an appointment, or cancel an appointment, except as provided for herein. Appointment to the Medical Staff shall confer to the appointee only such privileges as may hereinafter be provided.

3.4(b) Declaration of Moratorium

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

3.4(c) Reappointments

Reappointment to the Medical Staff shall be for a period not to exceed two (2) years.

3.4(d) Modification in Staff Category & Clinical Privileges

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

3.5 LEAVE OF ABSENCE

3.5(a) Leave Status

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

3.5(b) Termination of Leave

(3) At least sixty (60) days prior to the termination of leave, or at any earlier time, the staff member may request reinstatement of his/her privileges by submitting a written notice to that effect to the CEO or his/her designee for transmittal to the MEC. The staff member shall submit a written summary of his/her relevant activities during the leave. The MEC shall make a recommendation to the Board concerning the reinstatement of the member's privileges. Failure to request reinstatement in a timely manner shall result in automatic termination of staff membership, privileges and prerogatives without right of hearing or appellate review. Termination of Medical Staff membership, privileges and prerogatives pursuant to this section shall not be considered an adverse action, and shall not be reported to the Data Bank. A request for staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified for application for initial appointments.

(4) If a member requests leave of absence for the purpose of obtaining further medical training, reinstatement will ordinarily become automatic upon request for same, but only after the MEC has satisfied itself as to the continuing competency of the returning staff member. Any new privileges requested will be acted upon and monitored in similar fashion as if the member were a new applicant.

(5) Reinstatement will ordinarily be automatic if a leave of absence is for an armed services commitment. However, if such a leave of absence occurs with no medical activity for twelve (12) or more months, the MEC may require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to insure continuing competence.

(6) If a member requests leave of absence for reasons other than further medical training or an armed services commitment, the MEC may, prior to reinstatement, require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to insure continuing competence.

ARTICLE IV
MEDICAL STAFF CATEGORIES

4.1 CATEGORIES OF THE MEDICAL STAFF

The staff shall include Active, Courtesy, Consulting and Honorary categories. Qualifications, prerogatives, and responsibilities are outlined below. Failure to carry out the responsibilities or meet the qualifications as enumerated shall be grounds for corrective action, including, but not limited to, termination of staff membership.

4.2 ACTIVE STAFF

4.2(a) Qualifications

The Active Staff shall consist of practitioners who:

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

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

4.2(b) Prerogatives

The prerogatives of an Active Staff member shall be:

(1) To admit patients without limitation consistent with privileges granted (*unless seeking membership without privileges or "refer and follow" privileges only),* unless otherwise provided in the Medical Staff Bylaws or any rules or regulations adopted pursuant hereto;

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

(3) To vote on all matters presented at general and special meetings of the Medical Staff; to vote and hold office in the staff organization and on committees to which he/she is appointed; and to vote in all Medical Staff elections.

4.2(c) Responsibilities

Each member of the Active Staff shall:

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

(2) Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision. Requirements for timely assessment of admitted patients and consultations are located in Articles 1 and 3 of the Rules and Regulations; and

(3) Actively participate:

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

(ii) in supervision of other appointees where appropriate;

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

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

4.3 COURTESY STAFF

4.3(a) Qualifications

The Courtesy Staff shall consist of practitioners, who:

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

(2) Have an office and/or residence located within sufficient proximity of the Hospital in order to be continuously available for provision of care to his/her patients, as determined by the Board (unless requesting membership without privileges or "refer and follow" privileges only).

4.3(b) Prerogatives

The prerogatives of a Courtesy Staff member shall be to:

(1) To admit patients without limitation consistent with privileges granted (unless seeking membership without privileges or "refer and follow" privileges only), unless otherwise provided in the Medical Staff Bylaws or any rules or regulations adopted pursuant hereto;

(2) To exercise only such delineated clinical privileges as are granted to him/her pursuant to Article 7;

(3) Attend meetings of the staff; and

(4) Serve on any of the standing committees as a non-voting member on matters of policies and procedures, and shall not be entitled to vote at any general Medical Staff meeting.

4.3(c) Responsibilities

Each member of the Courtesy Staff shall:

(1) Meet the basic responsibilities specified in Article 3.3;

(2) Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision. Requirements for timely assessment of admitted patients and consultations are located in Articles 1 and 3 of the Rules and Regulations; and

(3) Actively participate:

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

(ii) in supervision of other appointees where appropriate;

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

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

4.4 CONSULTING STAFF

4.4(a) Qualifications

Consulting Staff shall consist of a special category of physicians each of whom is, because of board certification, training and experience, recognized by the medical community as an authority within his/her specialty.

4.4(b) Prerogatives

(1) Prerogatives of a Consulting Staff member shall be to:

(i) consult on patients within his/her specialty to the extent he/she holds delineated clinical privileges to do so; and

(ii) attend all meetings of the staff that he/she may wish to attend as a non-voting visitor.

(2) Consulting Staff members shall not hold office nor be eligible to vote in the Medical Staff organization; and

(3) Consulting Staff members with appropriate delineated clinical privileges may provide an unlimited number of consultation reports/recommendations (without managing the direct patient care) during a calendar year. Except where otherwise provided, Consulting Staff members shall not admit patients to the Hospital, transfer patients from the Hospital, or act as the physician of primary care or responsibility for any patient within the Hospital.

4.4(c) Responsibilities

Each member of the Consulting Staff shall:

(1) assume responsibility for consultation, treatment and appropriate documentation thereof with regard to his/her patients;

4.5 HONORARY STAFF

4.5(a) Membership on the Honorary Staff is restricted to two classes of practitioners:

(1) Former Staff members whom, upon retirement from practice, the Staff wishes to honor in recognition of longstanding service to the Hospital or other noteworthy contributions to its activities; and

(2) Other practitioners of outstanding professional attainments. None of the specific qualifications, prerogatives or obligations provided for other Staff categories are applicable to Honorary Staff members, and Honorary Staff members shall not be subject to the reappointment and/or evaluation procedures applicable to other Staff members.

4.5(b) Honorary Staff Limitations

Honorary Staff members shall have no clinical or other privileges and may not hold office in the Medical Staff organization.

4.6 LIMITATION OF PREROGATIVES

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

4.7 MEMBERSHIP WITHOUT DELINEATED CLINICAL PRIVILEGES

4.7(a) Membership Only

Practitioners who meet the general qualifications of these Medical Staff Bylaws and do not provide patient care in this Hospital may apply for Medical Staff membership without delineated clinical privileges. Practitioners who apply for Medical Staff membership only may apply for appointment to the Courtesy Staff.

4.7(b) Membership with Refer and Follow Privileges Only

Practitioners who do not wish to actively treat patients within the Hospital may seek "refer and follow" privileges only. These will permit the practitioner to refer patients to Medical Staff members for inpatient treatment. If the admitting/attending physician agrees, a practitioner with "refer and follow" privileges may visit his/her patients in the Hospital, review patient medical records and receive information concerning the patient's medical condition and treatment. However, under no circumstances shall a practitioner with "refer and follow" privileges participate in any treatment or procedure, make any entries in the medical record, or admit a patient to the Hospital.

4.8 MEDICAL RESIDENTS AND MEDICAL STUDENTS

4.8(a) Medical Residents

Residents shall be credentialed by the residency program in accordance with written affiliation agreement(s) between the Hospital and residency program and in accordance with Hospital policy. Residents shall be subject to the applicable policies and rules and regulations of the Fort Wayne Medical Education Program, and as outlined in the approved Medical Staff Policy. Residents are not granted independent privileges, and therefore every service provided by a resident within this Hospital is under the authority and credentials of a medical staff member with appropriate clinical privileges. The Fort Wayne Medical Education Program shall present an annual report to the MEC, only when activity has occurred at Rehabilitation Hospital during the calendar year.

4.8(b) Medical Students

Medical students shall engage in activity in the Hospital only pursuant to a written affiliation agreement between the Hospital and an approved medical college. Medical students shall be subject to the following rules, unless otherwise prohibited in the college affiliation agreement:

(1) Medical students shall provide services under the direct supervision of their medical education directors and/or the Medical Staff members to whom they are assigned;

(2) First and second-year medical students' activities shall be limited to the observation of patients and training in the taking of patient histories and the performance of physical examinations; and

(3) Third and fourth-year medical students may take histories and perform physicals, provided that records of such activities are countersigned by an attending member of the Medical Staff. Such students may also assist in invasive procedures, provided that such assistance occurs under the direct and continuing supervision of an appropriately-credentialed Staff member.

ARTICLE V
ALLIED HEALTH PROFESSIONALS (AHPs)

5.1 CATEGORIES

This article shall pertain only to Advanced Practice Allied Health Professionals ("AHPs"), that is, those who are credentialed pursuant to the Medical Staff process as outlined in the definition of "Allied Health Professional" herein. Clinical Assistants who are not Advanced Practice Allied Health Professionals and who are not credentialed pursuant to the Medical Staff process shall be governed by the applicable human resource policies of the Hospital. Allied Health Professionals may be employed by physicians on the staff; but whether or not so employed, must be under the direct supervision and direction of a staff physician who maintains clinical privileges to perform procedures in the same specialty area as the AHP.

5.2 QUALIFICATIONS

Only AHPs holding a license, certificate or other such credentials as may be required by applicable state law and the Hospital, shall be eligible to provide specified services in the Hospital as delineated by the MEC and approved by the Board.

5.2(a) AHPs must:

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

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

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

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

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

5.3 PREROGATIVES

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

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

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

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

5.4 CONDITIONS OF APPOINTMENT

5.4(a) AHPs shall be credentialed in the same manner as outlined in Article 6 of the Medical Staff Bylaws for credentialing of practitioners. Each AHP shall be assigned to one (1) of the clinical services and shall be granted scopes of practice/privileges relevant to the care provided in that clinical service. The Board in consultation with the MEC shall determine the scope of the activities/privileges which each AHP may undertake. Such determinations shall be furnished in writing to the AHP and shall be final and non-appealable, except as specifically and expressly provided in these bylaws.

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

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

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

5.4(e) If the supervising practitioner employs or directly contracts with the AHP for services, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, cause of actions, claims, damages, costs and expenses, including reasonable attorney fees,

resulting from, caused by or arising from improper or inadequate supervision of the AHP, negligence of such AHP, the failure such AHP to satisfy the standards of proper care of patients, or any action by such AHP beyond the scope of his/her license or scope of practice. If the supervising practitioner does not employ or directly contract with the AHP, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, causes of action, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP by the practitioner in question.

5.5 RESPONSIBILITIES

Each AHP shall:

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

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

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

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

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

5.5(f) Participate in performance improvement activities and in continuing professional education as required by licensure or certification;

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

5.5(h) Pay membership dues and other assessments as established by the MEC;

5.5(i) Must notify the Medical Staff Office and Medical Staff President within seven (7) days if:

(1) His/Her professional license or certification in any state is suspended or revoked, or if any investigation, sanction or notice of intent to sanction or to revoke, suspend or modify his/her license or certification;

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

(3) Any criminal charges, other than minor traffic violations, are brought/initiated against him/her and any guilty pleas or convictions entered; and

(4) He/she has been excluded, debarred, suspended, or otherwise declared ineligible from any federal or state health care or procurement program, including Medicare and Medicaid, has been convicted of a crime that meets the criteria for mandatory exclusion, debarment, suspension or ineligibility from such programs, or is under investigation by any such program;

Must notify the Medical Staff Office and Medical Staff President within thirty (30) days if:

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

(6) He/she is currently either voluntarily or involuntarily participating in any rehabilitation or impairment program, or has ceased participation in such a program without successful completion; and/or

(7) There has been involuntary limitation, reduction or loss of scope of practice or clinical privileges on any Medical Staff (including relinquishment of such AHP staff membership or scope of practice/clinical privileges after an investigation of competence, professional conduct, or patient care activities has commenced or to avoid such investigation; or receipt of sanction or notice of intent to sanction from any peer review or professional review body).

Failure to provide any such notice, as required above, may result in immediate loss of Allied Health membership and scope of practice/clinical privileges, without right of fair hearing procedures, as determined by the MEC.

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

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

5.5(l) Attest that he/she suffers from no health problems or mental condition which could affect ability to perform the functions of Allied Health membership and exercise the scope of practice/ privileges requested prior to initial exercise of scope of practice/privileges, and participate in the hospital drug testing program;

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

5.5(n) Refrain from engaging in business practices which are predatory or harmful to the Hospital or the community.

ARTICLE VI
INITIAL APPOINTMENT, REAPPOINTMENT, & PROVISIONAL/FPPE PERIOD

6.1 GENERAL PROCEDURES

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

6.2 CONTENT OF APPLICATION FOR INITIAL APPOINTMENT

Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form approved by the Board, and signed by the applicant. A copy of all active state licenses, current DEA registration/controlled substance certificate (for all practitioners except pathologists), a signed Medicare penalty statement and a certificate of insurance must be submitted with the application. Applicants shall supply the Hospital with all information requested on the application.

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

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

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

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

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

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

(d) Fraud and Civil Judgments related to Medical Practice: Any allegations of civil or criminal fraud pending against any applicant and any past allegations including their resolution and any investigations by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid; and any civil judgments or settlements related to the delivery of health care;

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

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

(g) Information on Malpractice Experience: All information concerning malpractice cases against the applicant either filed, pending, settled, or pursued to final judgment;

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

(i) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these bylaws, together with a letter from the insurer stating that the Hospital will be notified should the applicant's coverage change at any time;

(j) Notification of Release and Immunity Provisions: Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity and release provisions of Section 6.3(b) and (c);

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

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

(ii) specialty board certifications;

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

(iv) Drug Enforcement Agency (DEA) number/controlled substance license (except pathologists) (including any sanction or notice of intent to sanction or to revoke, suspend or modify his/her DEA number/controlled substance license);

(v) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges (including relinquishment of such medical staff membership or clinical privileges after an investigation of his competence, professional conduct, or patient care activities has commenced or to avoid such investigation; and receipt of a sanction or notice of intent to sanction from any peer review or professional review body); or

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

(vii) participation in any private, federal or state health care or procurement program, including Medicare or Medicaid, including conviction of a crime that meets the criteria for mandatory exclusion from such program, regardless of whether such exclusion has yet become effective.

If any such actions were taken, the particulars thereof shall be obtained before the application is considered complete.

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

(m) References: The names of at least three (3) practitioners (excluding employees or relatives), who have worked with the applicant within the past five (5) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training, experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others;

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

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

(p) Photograph: A recent, wallet sized photograph of the applicant;

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

(r) Professional Practice Review Data: For new applicants requesting new or additional privileges, evidence of professional practice review, volumes and outcomes from organization(s) that currently privilege the applicant may be required; and

(s) Continuing Education and Training: Evidence of satisfactory completion of continuing education requirements and other MEC directed education or safety training as required by this Hospital, which should be related to the physician's specialty and to the provision of quality patient care in the Hospital.

The applicant has a continuing duty to keep all of the above information updated and current. Failure to update anything on the above list within fourteen (14) days of any change or action while the application is pending shall result in a refusal to process the application, without Fair Hearing Rights. Failure to update within fourteen (14) days during any period of appointment or reappointment may result in immediate loss of medical staff membership and clinical privileges, without right of fair hearing procedures.

6.3 PROCESSING THE APPLICATION

6.3(a) Request for Application

An applicant wishing to be considered for appointment or reappointment and clinical privileges may obtain an application form therefore by submitting his/her request for an application packet to the Medical Staff Office.

6.3(b) Applicant's Burden

By submitting the application, the applicant:

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

(2) Authorizes Hospital representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her current competence and qualifications;

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

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

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

(6) Acknowledges that, if he/she is determined to have made a misstatement, misrepresentation, or omission in connection with an application and such misstatement, misrepresentation, or omission is discovered after appointment and/or the granting of clinical privileges, he/she shall be deemed to have immediately relinquished his/her appointment and clinical privileges, without fair hearing rights;

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

(8) Agrees to be bound by the statements described in Article 6.3(c).

6.3(c) Statement of Release & Immunity from Liability

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

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

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

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

If granted appointment, I accept the following conditions:

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

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

(ii) periodic reappraisals;

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

(iv) summary suspension;

(v) hearings and appellate reviews;

(vi) medical care evaluations;

(vii) utilization reviews;

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

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

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

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

(3) The term "Hospital" and "its authorized representatives" means the Hospital Corporation, the Hospital to which I am applying and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application or conduct in the Hospital: the members of the Board and their appointed representatives, the CEO or his/her designees, other Hospital employees, consultants to the Hospital, the Hospital's attorney and his/her partners, associates or designees, and all appointees to the Medical Staff. The term "third parties" means all individuals, including appointees to the Medical Staff, and appointees to the Medical Staffs of other Hospitals or other physicians or health practitioners, nurses or other government agencies, organizations, associations,

partnerships and corporations, whether Hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives or who have requested such information from the Hospital and its authorized representatives.

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

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

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

6.3(d) Submission of Application & Verification of Information

Upon completion of the application form and attachment of all required information, the Applicant shall submit the packet to the Medical Staff Office. The application may be returned to the applicant and shall not be processed further if one (1) or more of the following applies:

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

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

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

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

(5) Ineligible for Medicare Provider Status. The applicant has been excluded, suspended or debarred or declared ineligible from any state or federal health care program or procurement program, or is currently the subject of a pending investigation by such program or has been convicted of a crime that meets the criteria for mandatory exclusion (regardless of whether the provider has yet been excluded, debarred, suspended or otherwise declared ineligible); or

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

(7) Continuous Care Requirement. For applicants who will be seeking advancement to Active or Courtesy Staff, failure to maintain an office or residence within sufficient proximity of the Hospital or failure to indicate who will provide call coverage in his/her absence; or

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

(9) Electronic Health Record Education/Training: The applicant has failed to complete education in accordance with a facility approved curriculum related to electronic clinical information systems, or fails to appropriately utilize the Electronic Health Record as outlined in more detail in the Electronic Health Record Policy of this Hospital.

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

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

6.3(e) Description of Initial Clinical Privileges

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

6.3(f) Credentials Committee Action

Within forty (40) days of receiving the completed application, the members of the Credentials Committee shall review the application, the supporting documentation, the recommendation of the Clinical Service Chairperson and such other information available as may be relevant to consideration of the applicant's qualifications for the staff category and clinical privileges requested. The Credentials Committee shall transmit to the MEC on the prescribed form a written report and recommendation as to staff appointment and, if appointment is recommended, clinical privileges to be granted and any special conditions to be attached to the appointment. The Credentials Committee also may recommend that the MEC defer action on the application. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered by the committee. Documentation shall be transmitted with the report.

6.3(g) MEC Action

At its next regular meeting after receipt of the Credentials Committee recommendation, the MEC shall consider the recommendation and other relevant information available to it. Where there is doubt about an applicant's ability to perform the privileges requested, the MEC may request an additional evaluation. The MEC shall make specific findings as to the applicant's satisfaction of the requirements of experience, ability, and current competence as set forth in Section 6.3(n). The MEC shall then forward to the Board a written report on the prescribed form concerning staff recommendations and, if appointment is recommended, staff category and clinical privileges to be granted and any special conditions to be attached to the appointment. The MEC also may defer action on the application. The reasons for each recommendation shall be stated and supported by reference to the completed application and other information considered by the committee. Documentation shall be transmitted with the report.

6.3(h) Effect of MEC Action

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

(2) Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the CEO or his/her designee shall promptly forward it, together with all supporting documentation, to the Board

(3) Adverse Recommendation: When the recommendation of the MEC is adverse to the applicant, the CEO or his/her designee shall immediately inform the applicant by special

notice, which shall specify the reason or reasons for denial, and the applicant then shall be entitled to the procedural rights as provided in the Fair Hearing Plan, or for AHPs, the procedure outlined in Article 5.4(b). The applicant shall have an opportunity to exercise his/her procedural rights prior to submission of the adverse recommendation to the Board. For the purpose of this section, an "adverse recommendation" by the MEC is defined as denial of appointment, or denial or restriction of requested clinical privileges. Upon completion of the Fair Hearing process, the Board shall act in the matter as provided in the Fair Hearing Plan, or for AHPs, the procedure outlined in Article 5.4(b).

6.3(i) Board Action

(1) Decision; Deadline. The Board shall act upon the recommendation at its next scheduled meeting, or may defer action if additional information or clarification of existing information is needed, or if verification is not yet complete. The Board may accept, reject or modify the MEC recommendation.

(2) Favorable Action. In the event that the Board' decision is favorable to the applicant, such decision shall constitute final action on the application. The CEO or his/her designee shall promptly inform the applicant that his/her application has been granted. The decision to grant Medical Staff appointment or reappointment, together with all requested clinical privileges, shall constitute a favorable action even if the exercise of clinical privileges is made contingent upon monitoring, proctoring, periodic drug testing, additional education concurrent with the exercise of clinical privileges, or any similar form of performance improvement that does not materially restrict the applicant's ability to exercise the requested clinical privileges.

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

Under no circumstances shall any applicant be entitled to more than one (1) evidentiary hearing under the Fair Hearing Plan based upon an adverse action.

6.3(j) Interview

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

6.3(k) Reapplication After Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be considered for appointment to the Medical Staff for a period of one (1) year after notice of such decision is sent, or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. An applicant who has received a final adverse decision as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty shall not be permitted to reapply for a period of five (5) years after notice of the final adverse decision is sent.

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

6.3(l) Time Periods for Processing

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

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

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

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

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

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

However, upon written request of the applicant, the application shall be kept in a pending status for the next succeeding two (2) years. If during this period, the hospital finds it possible to accept applications for staff positions for which the applicant is eligible, and the hospital has no obligation to applicants with prior pending status, the CEO or his/her designee shall promptly so inform the applicant of the opportunity by special notice.

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

6.3(n) Appointment Considerations

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

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

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

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

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

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

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

6.4 REAPPOINTMENT PROCESS

6.4(a) Application for Reappointment

At least ninety (90) days prior to the expiration date of an applicant's present staff appointment, the Medical Staff Office shall provide the applicant a reappointment application for use in considering reappointment. The staff member who desires reappointment shall, at least sixty (60) days prior to such expiration date, complete the reapplication form by providing updated information with regard to his/her practice during the previous appointment period, and shall forward his/her reappointment application to the Medical Staff Office. Failure to return a completed application form shall result in automatic termination of membership at the expiration of the member's current term.

6.4(b) Content of Reappointment Application

The reappointment application shall include, at a minimum, updated information regarding the following:

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

(2) License: Current valid medical, dental, or other professional licensure or certifications as applicable, and Drug Enforcement Administration registration and Indiana Controlled Substances Certificate (DEA and CSR not required for pathologists);

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

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

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

(6) Professional Sanctions: Information as to previously successful or currently pending actions including challenges to, denial, revocation, suspension, reduction, limitation, probation, non-renewal or the voluntary relinquishment of, any of the following during the preceding appointment period:

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

(ii) specialty or subspecialty board certification or eligibility; or

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

(iv) Drug Enforcement Agency (DEA) number/controlled substance license (except for pathologists) (including any sanction or notice of intent to sanction or to revoke, suspend or modify his/her DEA number/controlled substance license); or

(v) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges (including relinquishment of such medical staff membership or clinical privileges after an investigation of competence, professional conduct, or patient care activities has commenced or to avoid such investigation; or receipt of a sanction or notice of intent to sanction from any peer review or professional review body); or

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

(vii) participation in any private, federal or state health care or procurement program, including Medicare or Medicaid, including conviction of a crime that meets the criteria for mandatory exclusion from such program, regardless of whether such exclusion has yet become effective.

If any such actions were taken, the particulars thereof shall be obtained before the application is considered complete.

(7) Insurance/Information on Malpractice Experience: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these bylaws, together with a letter from the insurer stating that the Hospital will be notified should the applicant's coverage change at any time. Also, all information concerning malpractice cases against the applicant either filed, pending, or pursued to final judgment since last appointment;

(8) Criminal Charges: Any current criminal charges pending against the applicant, including any federal and/or state criminal convictions related to the delivery of health care, and any convictions or pleas during the preceding appointment period. This includes any arrests related to the use, misuse or abuse of drugs or alcohol including DUIs and DWIs;

(9) Fraud and Civil Judgments related to Medical Practice: Any allegations of civil or criminal fraud pending against any applicant and any allegations resolved during the preceding appointment period, as well as any investigations during the preceding appointment period by any private, federal or state agency concerning participation in any health insurance

program, including Medicare or Medicaid during the preceding appointment period; and any civil judgments or settlements related to the delivery of health care;

(10) Privileges: Specific request for the clinical privileges sought at reappointment, with required documentation of education and training for additional privileges requested;

(11) Staff Status: Specific request for staff status sought at reappointment. All staff statuses must meet the basic qualifications set forth in these bylaws;

(12) Current Competency: Objective evidence of the individual's clinical performance, competence, and judgment, based on the findings of clinical service evaluations of care, including, but not limited to an evaluation by a peer reference (colleague in the same specialty) to attest to the member's current clinical competence and health status. Such evidence shall include as the results of the applicant's ongoing practice review, including data comparison to peers, core measures, outcomes, and focused review outcomes during the prior period of appointment. Applicants who have not actively practiced in this Hospital or have fewer than five (5) admissions, discharges, consultations, procedures, or any combination of these during the prior appointment period will have the burden of providing evidence of the applicant's professional practice review, volumes and outcomes from organizations that currently privilege the applicant and where the applicant has actively practiced during the prior period of appointment;

(13) Notification of Release & Immunity Provisions: The acknowledgments and statement of release set forth in Article 6.3(b) and (c);

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

(15) Peer Reference: The name of one practitioner (excluding employees or relatives) practicing in the same specialty, who has worked with the applicant within the past two (2) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training and experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others;

(16) Continuing Education and Training: Evidence of satisfactory completion of continuing education requirements per Medical Staff policy (achievement of initial board certification or recertification during the applicable reappointment period shall fulfill this requirement) and other MEC directed education or safety training as required by this Hospital, which should be related to the physician's specialty and to the provision of quality patient care in the Hospital; and

(17) Board Certification Status: Initial certification date, date recertified, expiration of certification, or plan to achieve board certification following recent completion of residency/fellowship training.

The applicant has a continuing duty to keep all of the above information updated and current. Failure to update anything on the above list within seven (7) days of any change or action while the application is pending shall result in a refusal to process the application, without Fair Hearing Rights. Failure to update within seven (7) days during any period of appointment or reappointment shall result in immediate loss of medical staff membership and clinical privileges, without right of fair hearing procedures.

6.4(c) Verification of Information

The Medical Staff Office shall, in timely fashion, verify the information made available on each reappointment application and collect any other materials or information deemed pertinent, including information regarding the staff member's professional activities, performance and conduct in the hospital and the query of the Data Bank. A peer recommendation will be collected and considered in the reappointment process. During the reappointment process, the hospital shall not routinely perform criminal checks unless circumstances otherwise dictate. The applicant has the burden of producing adequate information and resolving any doubts about the data. When collection and verification are accomplished, the Medical Staff Office shall transmit the reappointment application and supporting materials to the Credentials Committee. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

The schedule for the reappointment process shall be as follows:

March	Anesthesiology, Dentistry, Pathology, Radiology
May	Obstetrics-Gynecology, Pediatrics, Cardiology/Cardiovascular
July	Medicine (includes all sections/subspecialties)
September	Family Practice, Psychiatry
November	Surgery (includes all sections/subspecialties)

6.4(d) Action on Application

The application for reappointment shall thereafter be processed as set forth as described in Article 6.3(g) - 6.3(l) for initial appointment; except that an individual whose application for reappointment is denied shall not be permitted to reapply for a period of five (5) years or until the defect constituting the basis for the adverse action is corrected, whichever is later. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the staff or the Board may require.

6.4(e) Basis for Recommendations

Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall be based upon an evaluation of the considerations described in Article 6.3(o) as they impact upon determinations regarding the member's professional performance, ability and clinical judgment in the treatment of patients, his/her discharge of staff obligations, including participation in continuing medical education, his/her compliance with the Medical Staff Bylaws, Rules & Regulations, his/her cooperation with other practitioners and AHPs and with patients, results of the hospital monitoring and evaluation process, including practitioner and AHP-specific information compared to aggregate information from Performance Improvement activities which consider criteria directly related to quality of care, and other matters bearing on his/her ability and willingness to contribute to quality patient care in the hospital.

6.4(f) Provisional Period/Focused Professional Practice Evaluation (FPPE) Process

This section outlines the provisional period/FPPE requirements for newly appointed members of the Medical Staff granted clinical privileges. All applicants shall be subject to a Focused Professional Practice Evaluation during the provisional period.

Not later than six months after a practitioner's appointment to the Staff, the Medical Staff Office shall gather the following information for review and consideration by the Credentials Committee, MEC, and the Board:

(1) Performance evaluation from the previously designated proctor, if one has been assigned, including his/her recommendations for continued membership and privileges;

(2) Clinical activity report; and

(3) Evaluation and recommendation from the chairman of Credentials Committee that the practitioner has satisfactorily demonstrated his ability to exercise those privileges.

The applicant shall have at least five (5) admissions, discharges, consultations, procedures or any combination of these during his/her provisional/FPPE period. At the discretion of the Credentials Advisor, only those physicians whose particular specialties do not allow them the opportunity to practice routinely within the hospital setting, for example but not limited to allergy care, dentistry, dermatology, and rheumatology the Credentials Committee may elect to recommend favorable conclusion of the provisional/FPPE period.

If the hospital's current reporting mechanisms are unable to capture certain activity, e.g., progress notes, consultations, etc., it is the applicant's responsibility to document the patient encounters and submit adequate patient identifying information to the Medical Staff Office.

If an initial appointee or Staff member is unable to obtain favorable Subsections 1-3 required of him/her because his/her case load at the Hospital was inadequate to demonstrate the ability to exercise the privileges requested, the practitioner's provisional period may be extended for one additional six-month period, unless the Board, after receiving the recommendations of the MEC, determines such extension is inappropriate. Only one automatic extension is permissible. Failure to receive such an extension, or failure to satisfy the requirements at the completion of an extension, shall result in an automatic suspension of membership and shall be considered a voluntary relinquishment of any and all clinical privileges.

6.5 REQUEST FOR MODIFICATION OF STATUS OR PRIVILEGES

A staff member may, either in connection with reappointment or at any other time, request modification of his/her staff status or clinical privileges, by submitting the request in writing to the Medical Staff Office. Such request shall be processed in substantially the same manner as provided in Article 6.4 for reappointment. No staff member may seek modification of privileges or staff category previously denied on initial appointment or reappointment unless supported by documentation of additional training and experience.

6.6 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

6.6(a) Qualifications & Processing

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

6.6(b) Requirements for Service

In approving any such practitioners or AHPs for Medical Staff membership, the Medical Staff must require that the services provided meet Joint Commission requirements, are subject to appropriate quality controls, and are evaluated as part of the overall hospital quality assessment and improvement program.

6.6(c) Termination

Unless otherwise provided in the contract for services, expiration or termination of any exclusive contract for services pursuant to this Section 6.6, shall automatically result in concurrent termination of Medical Staff membership and clinical privileges. The Fair Hearing does not apply in this case.

ARTICLE VII
DETERMINATION OF CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Every practitioner or AHP providing direct clinical services at this Hospital shall, in connection with such practice and except as provided in Article 7.5, be entitled to exercise only those clinical privileges or services specifically granted to him/her by the Board. Said privileges must be within the scope of the license authorizing the practitioner or AHP to practice in this state and consistent with any restrictions thereon. The Board shall approve the list of specific privileges and limitations for each category of practitioner and AHP, and each practitioner or AHP shall bear the burden of establishing his/her qualifications to exercise each individual privilege granted.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2(a) Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. The request for specific privileges must be supported by documentation demonstrating the practitioner or AHP's qualifications to exercise the privileges requested. In addition to meeting the general requirements of these Bylaws for medical staff membership, each practitioner and AHP must provide documentation establishing that he/she meets the requirements for training, education and current competence set forth in any specific credentialing criteria applicable to the privileges requested. A request by a staff member for a modification of privileges must be supported by documentation supportive of the request.

7.2(b) Basis for Privileges Determination

Granting of clinical privileges shall be based upon available facilities, equipment and number of qualified support personnel and resources as well as on the practitioner or AHP's education, training, current competence, including documented experience in treatment areas or procedures; the results of treatment; and the conclusions drawn from performance improvement activities, when available. For practitioners or AHPs who have not actively practiced in the hospital within the prior appointment period, information regarding current competence shall be obtained in the manner outlined in Article 6.4(b)(12) herein. In addition, those practitioners or AHPs seeking new, additional or renewed clinical privileges (except those seeking emergency privileges) must meet all criteria for Medical Staff membership as described in Article 7 of these Bylaws, including a query of the National Practitioner Data Bank. When privilege delineation is based primarily on experience, the individual's credentials record should reflect the specific experience and successful results that form the basis for granting of privileges, including information pertinent to judgment, professional performance and clinical or technical skills. Clinical privileges granted or modified on pertinent information concerning clinical performance obtained from other health care institutions or practice settings shall be added to and maintained in the Medical Staff file established for a staff member or AHP.

7.2(c) Procedure

All requests for clinical privileges shall be evaluated and granted, modified or denied pursuant to the procedures outlined in Article VI and shall be granted for a period not to exceed two (2) years. The Data Bank shall be queried each time new privileges are requested.

7.2(d) Limitations on Privileges

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

7.2(e) Initial and Additional Grants of Privileges

All initial appointments and grants of new or additional privileges to existing members of the Medical Staff shall be subject to a period of focused professional practice evaluation for a period up to six (6) months. The evaluation period may be renewed for one additional six (6) month period, unless the Board, after receiving the recommendation of the Executive Committee, determines such extension is inappropriate. Results of the focused professional practice evaluation conducted during the period of appointment shall be incorporated into the practitioner or AHP's evaluation for reappointment.

7.3 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS

7.3(a) Temporary Privileges

Temporary privileges may only be granted when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time, while full credentials information is verified and approved. An example would be a situation in which a physician is involved in an accident or becomes suddenly ill, and a practitioner is needed to cover his/her practice immediately. In these cases only, the CEO or his/her designee, upon recommendation of the Medical Staff President may grant such privileges upon completion of the appropriate application packet and submission of current curriculum vitae, photograph, Indiana medical license, Indiana State Controlled Substance Registration, DEA certificate, appropriate malpractice insurance, and completion of the required Data Bank query, and upon verification that there are no current or prior successful challenges to licensure or registration, that the physician has not been subject to involuntary termination of Medical Staff membership at another facility, and likewise has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges at another facility.

Except as provided above, temporary privileges may not be granted pending processing of applications for appointment or reappointment.

7.3(b) One-Case Privileges

Upon receipt of a written request, an appropriately licensed person who is not an applicant for membership may be granted temporary privileges for the care of one (1) specific patient. In these cases, the CEO or his/her designee and the Medical Staff President may grant such privileges. Such privileges are intended for isolated instances in which extension of such privileges are shown to be in an individual patient's best interest, and no practitioner shall be granted one-case privileges on more than five (5) occasions in any given year. The letter approving such privileges shall include the name of the patient to be treated and the specific privileges granted. Practitioners granted one-case privileges may attend the patient for whom privileges were granted for the duration of the hospitalization. If a given practitioner exceeds the five (5) case limit, such person shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients. Prior to any award of one-case privileges, the practitioner must submit the following: A written request including patient's name, procedure/treatment to be performed; date of procedure/treatment; signed Agreement and Authorization for Release of Information; CV including date of birth and social security number; current Indiana medical license; current

Indiana State Controlled Substance Registration; current DEA certificate, and proof of appropriate and current malpractice insurance. Data Bank query must be performed and the CEO or his/her designee must obtain verification of the physician's unrestricted privileges at his/her primary hospital.

7.3(c) Locum Tenens

Upon receipt of a written request, an appropriately licensed person who is serving as locum tenens for a member of the Medical Staff may, without applying for membership on the staff, be granted temporary privileges by the CEO or his/her designee and Medical Staff President Chair of the Credentials Committee and Chairperson of the applicable clinical service for an initial period not to exceed 60 days. Such privileges may be automatically renewed for one (1) successive consecutive period not to exceed 60 days. In no event shall the individual exceed one hundred and twenty (120) days of service as a locum tenens within a calendar year. All physicians providing coverage through such locum tenens services must ensure that all legal requirements, including billing and reimbursement regulations, are met. The Data Bank query must be completed prior to any award of locum tenens privileges pursuant to this section. Further, prior to award of locum tenens privileges, the applicant must complete the appropriate application packet and submit current photograph, Indiana medical license, Indiana State Controlled Substance Registration, DEA certificate, proof of appropriate malpractice insurance and curriculum vitae. The CEO or his/her designee must obtain verification of the physician's privileges at his/her primary hospital. The letter approving locum tenens privileges shall identify the specific privileges granted.

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

7.3(d) Proctoring Privileges

Upon receipt of a written request, an appropriately licensed person who is serving as a proctor participating in direct patient care (hands-on) for a member of the Medical Staff may, without applying for membership on the staff, be granted temporary privileges by the CEO or his/her designee and Medical Staff President for an initial period not to exceed sixty (60) days. Such privileges may be automatically renewed for one (1) successive period not to exceed sixty (60) days. In no event shall the individual exceed one hundred and twenty (120) days of service as a proctoring physician within a calendar year. The Data Bank query must be completed prior to any award of proctoring privileges pursuant to this section. Further, prior to award of proctoring privileges, the applicant must submit a current curriculum vitae (including date of birth and SSN for Data Bank query), consent and release, medical license, state controlled substance registration (if applicable), DEA certificate, proof of malpractice insurance, and any other requested information. The CEO or his/her designee must obtain verification of the physician's privileges at his/her primary hospital (if applicable). The letter approving proctoring privileges shall identify the specific privileges granted.

7.3(e) Conditions

Temporary, one-case and locum tenens privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting applicant's qualifications, ability and judgment to exercise the privileges granted. Special requirements of consultation and reporting may be imposed by the Medical Staff President, including a

requirement that the patients of such applicant be admitted upon dual admission with a member of the Active Staff. Before temporary or locum tenens privileges are granted, the applicant must acknowledge in writing that he/she has received and read the Medical Staff Bylaws, Rules & Regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her privileges.

7.3(f) Termination

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

7.3(g) Rights of the Practitioner

A practitioner shall not be entitled to the procedural rights afforded by these bylaws because of his/her inability to obtain temporary, one-case or locum tenens privileges or because of any termination or suspension of such privileges.

7.3(h) Term

No term of temporary, one-case, locum tenens, or proctoring privileges shall exceed a total of one hundred and twenty (120) days per calendar year.

7.4 EMERGENCY & DISASTER PRIVILEGES

For the purpose of this section, an "emergency" is defined as a condition in which serious or permanent harm to a specific patient is imminent, or in which the life of a specific patient is in immediate danger, delay in administering treatment immediately would add to that danger and no appropriately credentialed individual can be available in the time required to respond. A "disaster" for purposes of this section is defined as a community-wide disaster or mass injury situation in which the number of existing, available medical staff members is not adequate to provide all clinical services required by the citizens served by this facility. In the case of an emergency, or disaster as defined herein, any practitioner, or licensed independent practitioner, to the degree permitted by his/her license and regardless of staff status or clinical privileges, shall, as approved by the CEO or his/her designee or the Medical Staff President, be permitted to do, and be assisted by hospital personnel in doing everything reasonable and necessary to save the life of a patient or to prevent imminent harm to the patient.

Disaster privileges may be granted by the CEO or his/her designee or Medical Staff President when, and for so long as, the Hospital's emergency management plan has been activated and the hospital is unable to handle the immediate patient needs. Prior to granting any disaster privileges the volunteer practitioner, or licensed independent practitioner, shall be required to present a valid photo ID issued by a state, federal or regulatory agency, and at least one of the following: a current hospital picture ID which clearly identifies professional designation; a current license, certification or registration; primary source verification of licensure, certification or registration (if required by law to practice a profession); ID indicating the individual is a member of a Disaster Medical Assistance Team (DMAT), or the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health

Professionals (ESAR-VHP); ID indicating the individual has been granted authority to render patient care, treatment, and services in a disaster; or ID of a current medical staff member who possesses personal knowledge regarding the volunteer practitioner's qualifications. The CEO or his/her designee and/or Medical Staff President are not required to grant such privileges to any individual and shall make such decisions only on a case-by-case basis.

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

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

7.5 TELEMEDICINE

7.5(a) Scope of Privileges

The Medical Staff shall make recommendations to the Board regarding which clinical services are appropriately delivered through the medium of telemedicine, and the scope of such services. Clinical services offered through this means shall be provided consistent with commonly accepted quality standards.

7.5(b) Telemedicine Physicians

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

In circumstances in which the distant-site entity or hospital is Joint Commission accredited, the Medical Staff and Board may rely on the telemedicine physician's credentialing information from the distant-site entity or distant-hospital to credential and privilege the telemedicine physician ONLY if the Hospital has ensured through a written agreement with the distant-site entity or distant-site hospital that all of the following provisions are met:

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

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

(3) The distant-site organization is either a Medicare-participating hospital or a distant-site telemedicine entity with medical staff credentialing and privileging processes and standards that at least meet the standards set forth in the CMS Hospital Conditions of Participation;

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

(5) The telemedicine physician holds a license issued or recognized by the state in which the Hospital is located; and

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

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

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

ARTICLE VIII
CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1(a) Criteria for Initiation

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

8.1(b) Request & Notices

All requests for corrective action under this Article 8.1 shall be submitted in writing to the MEC, and supported by reference to the specific activities or conduct which constitute the grounds for the request. The Medical Staff President shall promptly notify the CEO or his/her designee in writing of all requests for corrective action received by the committee and shall continue to keep the CEO or his/her designee fully informed of all action taken in conjunction therewith.

8.1(c) Investigation by the MEC

The MEC shall begin to investigate the matter within forty-five (45) days or at its next regular meeting whichever is sooner, or shall appoint an ad hoc committee to investigate it. When the investigation involves an issue of physician impairment, the MEC shall assign the matter to an ad hoc committee of three (3) members who shall operate apart from this corrective action process, pursuant to the provisions of the Hospital's Impaired Physician Policy. Within thirty (30) days after the investigation begins, a written report of the investigation shall be completed.

8.1(d) MEC Action

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

(1) Rejecting the request for corrective action;

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

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

(4) Recommending terms of probation or required consultation;

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

(6) Recommending reduction of staff category or limitation of any staff prerogatives; or

(7) Recommending suspension or revocation of staff membership.

8.1(e) Procedural Rights

Any action by the MEC pursuant to Article 8.1(d)(4), (5), (6), or (7) (where such action materially restricts a practitioner's exercise of privileges) or any combination of such actions, shall entitle the physician or dentist to the procedural rights as specified in the provisions of Article IX and the Fair Hearing Plan. The Board may be informed of the recommendation, but shall take no action until the member has either waived his/her right to a hearing or completed the hearing.

8.1(f) Other Action

If the MEC's recommended action is as provided in Article 8.1(d)(1), (2), (3) or (d)(4) (where such action does not materially restrict a practitioner's exercise of privileges), such recommendation, together with all supporting documentation, shall be transmitted to the Board. The Fair Hearing Plan shall not apply to such actions.

8.1(g) Board Action

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

8.2 SUMMARY SUSPENSION

8.2(a) Criteria & Initiation

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

Immediately upon the imposition of summary suspension, the Medical Staff President or his/her designee shall designate a physician with appropriate clinical privileges to provide continued medical care for the suspended practitioner's patients still in the hospital. The wishes of the patient shall be considered, if feasible, in the selection of the assigned physician.

It shall be the duty of all Medical Staff members to cooperate with the Medical Staff President and the CEO or his/her designee in enforcing all suspensions and in caring for the suspended practitioner's patients.

8.2(b) MEC Action

Within seventy-two (72) hours after such summary suspension, a meeting of the MEC shall be convened to review and consider the action taken. The MEC may recommend modification, ratification, continuation with further investigation or termination of the summary suspension.

8.2(c) Procedural Rights

If the summary suspension is terminated or modified such that the practitioner's privileges are not materially restricted, the matter shall be closed and no further action shall be required.

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

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

8.3 ADMINISTRATIVE CORRECTIVE ACTION

8.3(a) Criteria for Initiation

Whenever a practitioner violates Hospital policies, rules or regulations, exhibits behavior that undermines a culture of safety or acts in a manner disruptive to hospital operations, or in such a manner as to endanger the assets of the hospital because of financially imprudent actions not justified by patient care considerations, administrative corrective action may be initiated pursuant to the Hospital Policy regarding behavior that undermines the culture of safety. Such action shall be taken pursuant to this section, in conjunction with the above policy, rather than Article 8.1 or 8.2, only in those instances in which disruptive or inappropriate conduct, rather than clinical competency is in question. Such instances may include, but are not limited to, abusive treatment of hospital employees, refusal to discharge Medical Staff duties unrelated to patient care, violation of policies, rules or regulations, or harassment.

8.3(b) Corrective Action by the MEC and/or Board

If collegial intervention and progressive discipline pursuant to the Code of Conduct, Civility and Respect Policy is not successful in remediating the issue, the MEC and/or Board may take action as provided herein. If the MEC addresses the issue, the procedure in Article 8.1 shall apply. If the MEC elects to refer the matter directly to the Board, or the Board takes action on its own initiative, the Board may commence an investigation. The CEO or his/her designee shall be responsible for presenting the history of conduct to the Board. The Board shall be fully apprised of the previous meetings and warnings, if any, so that it may pursue whatever action is necessary to terminate the unacceptable conduct. Should the Board determine that further investigation is necessary, the Board Chairperson shall appoint an individual or an ad hoc committee to investigate and report back to the Board at its next regular meeting. Within thirty (30) days after the investigation begins, a written report of the investigation shall be completed.

8.3(c) Board Action

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

(1) Rejecting the request for corrective action;

(2) Issuing a warning or a reprimand to which the practitioner may write a rebuttal, if he/she so desires;

(3) Requiring terms of probation or required consultation;

(4) Reducing, suspending or revoking clinical privileges;

(5) Reducing staff category or limiting prerogatives; or

(6) Suspending or revoking staff membership.

8.3(d) Procedural Rights

Any action by the Board pursuant to Article 8.3(c)(4), (5) or (6), or (c)(3) (where such action materially restricts a practitioner's exercise of privileges) or any combination of such actions, shall entitle the practitioner to the procedural rights as specified in the provisions of Article IX and the Fair Hearing Plan. The action will not become final until the practitioner has either waived his/her right to a hearing or completed the hearing.

8.3(e) Other Action

If the Board's action is as provided in Article 8.3(c)(1) and (2), or (c)(3) (where such action does not materially restrict a practitioner's exercise of privileges), such action shall become the final action of the Board, and the practitioner shall not be entitled to the rights enumerated in the Fair Hearing Plan.

8.4 AUTOMATIC SUSPENSION

8.4(a) License

A staff member or AHP whose license, certificate, or other legal credential authorizing him/her to practice in Indiana is revoked, relinquished, suspended or restricted shall immediately and automatically be suspended from the staff and practicing in the hospital until such time as the license, certificate or other legal credential is reinstated.

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

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

8.4(c) Medical Records

All Medical records shall be completed within 30 days of discharge. The Hospital Policy titled "Medical Record Delinquency" defines and outlines the corrective action process for physicians with delinquent medical records up to and including potential automatic suspension and denial of reappointment to the Medical Staff.

8.4(d) Malpractice Insurance Coverage

Any practitioner or AHP unable to provide proof of current medical malpractice coverage as a certified and qualified health care provider in the amounts prescribed under the Indiana Medical Malpractice Act will be automatically suspended until proof of such coverage is provided.

8.4(e) Failure to Appear/Cooperate

Failure of a practitioner or AHP to appear at any meeting with respect to which he/she was given such special notice and/or failure to comply with any reasonable directive of the MEC shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner or AHP's clinical privileges as the MEC may direct. In addition, failure to complete required initial training or training updates regarding electronic health information systems as directed by the MEC and more specifically described in the facility's Electronic Health Record Policy shall result in automatic suspension until such training is completed.

8.4(f) Exclusions/Suspension from Medicare

Any practitioner or AHP who is excluded, debarred, suspended or otherwise declared ineligible from any state or federal government health care program or procurement program or has been convicted of a crime that meets the criteria for mandatory exclusion (regardless of whether the provider has yet been excluded, debarred, suspended or otherwise declared ineligible) will be automatically suspended.

8.4(g) Dues

Failure of a physician or AHP to pay dues as established by the Executive Committee shall result in automatic suspension until such payment has been made.

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

No staff member whose privileges are automatically suspended under this Section 8.4, shall have the right of hearing or appeal as provided under Article IX of these bylaws. The Medical Staff President shall designate a physician to provide continued medical care for any suspended practitioner's patients.

8.4(i) Medical Staff President

It shall be the duty of the Medical Staff President to cooperate with the CEO or his/her designee in enforcing all automatic suspensions and expulsions and in making necessary reports of same. The CEO or his/her designee shall periodically keep the Medical Staff President informed of the names of staff members who have been suspended or expelled under Article 8.4.

8.5 SUMMARY SUPERVISION

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

8.6 CONFIDENTIALITY OF INFORMATION

Information with respect to any practitioner or AHP submitted, collected, or prepared by any representative of this or any other health care facility or organization or Medical Staff for the purpose of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, determining that health care services are professionally indicated or were performed in compliance with the applicable standards of care, or establishing and

enforcing guidelines to keep health care costs within reasonable bounds shall be confidential to the fullest extent permitted by law, and shall neither be disseminated to anyone other than a representative nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's record.

8.7 IMMUNITY FROM LIABILITY

8.7(a) For Action Taken

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

8.7(b) For Providing Information

Each representative of the Medical Staff and Hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or hospital concerning such person who is, or has been, an applicant to or member of the Staff or who did, or does, exercise clinical privileges or provide services at this Hospital.

8.8 ACTIVITIES AND INFORMATION COVERED

8.8(a) Activities

The confidentiality and immunity provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions, or disclosures performed or made in connection with this or any other health care facility's or organization's activities covering, but not limited to the following areas:

(1) applications for appointment, clinical privileges, or specified services;

(2) periodic reappraisals for reappointment, clinical privileges, or specified services;

(3) corrective or disciplinary action;

(4) hearings and appellate reviews;

(5) quality assurance program activities;

(6) utilization reviews;

(7) claims reviews;

(8) profiles and profile analysis;

(9) malpractice loss prevention; and

(10) other Hospital and Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

8.8(b) Information

The information referred to in this Article may relate to a practitioner's or specified professional personnel's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

8.8(c) Releases

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

8.9 CUMULATIVE EFFECT

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

8.10 REAPPLICATION AFTER ADVERSE ACTION

An applicant who has received a final adverse decision pursuant to Article 8.1, 8.2 or 8.3 shall not be considered for appointment to the Medical Staff for a period of five (5) years after notice of such decision is sent or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the staff or the Board may require.

8.11 FALSE INFORMATION ON APPLICATION

Any practitioner or AHP who, after being granted appointment and/or clinical privileges, is determined to have made a misstatement, misrepresentation, or omission in connection with an application may result in immediate relinquishment of his/her appointment and clinical privileges. No practitioner or AHP who is deemed to have relinquished his/her appointment and clinical privileges pursuant to this Article 8.9 shall be entitled to the procedural rights under these Bylaws and the Fair Hearing Plan, except that the MEC may, upon written request from the practitioner or AHP, permit the practitioner or AHP to appear before it and present information solely as to the issue of whether the practitioner or AHP made a misstatement, misrepresentation, or omission in connection with his/her application. If such appearance is permitted by the MEC, the MEC shall review the material presented by the practitioner or AHP and render a decision as to whether the finding that he/she made a misstatement, misrepresentation, or omission was reasonable, which MEC decision shall be subject to the approval of the Board.

ARTICLE IX
INTERVIEWS & HEARINGS

9.1 INTERVIEWS

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

9.2 HEARINGS

9.2(a) Procedure

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

9.2(b) Exceptions

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

9.3 ADVERSE ACTION AFFECTING AHPS

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

ARTICLE X
STAFF OFFICERS

10.1 GENERAL OFFICERS OF THE STAFF

10.1(a) Identification

(1) President

(2) Vice President (President Elect)

(3) Immediate Past President

10.1(b) Qualifications

(1) Each general officer must be a member of the Active Staff at the time of nomination and election, must remain a member in good standing continuously during his term of office, and must be willing and able to faithfully discharge the duties of the office held. The President and Vice President must have demonstrated executive ability and be recognized for their high level of clinical competence.

(2) A member may not hold two general Staff offices concurrently.

(3) A member serving as a Medical Staff officer or as a member of the MEC may not serve as a Medical Staff or corporate officer, department chief, Credentials Committee chairperson or in any other official, recognized capacity at another hospital, and he may not so serve at another hospital during his term of office. Nothing herein, however, shall be construed to prohibit a Medical Staff Officer or MEC member from serving as a member of a medically-related, nongoverning Medical Staff committee at another hospital.

(4) A member may serve as Medical Staff Officer when his election or appointment as an officer is confirmed by the Board.

10.1(c) Nominations

The Nominating Committee shall consist of the members of the MEC, as all clinical services are represented; the Chief Executive Officer or his/her designee, who shall serve as an ex officio voting member of the committee; and the Immediate Past President, who shall serve as an ex officio voting member of the committee. It shall be the purpose of this committee to select the most qualified candidates willing and able to accept major administrative responsibility for the Medical Staff.

A single meeting in July shall be held at a time and in a place specified by the Chairman of the MEC. In the event that attendance is below the quorum, the chairman shall fix an alternate meeting date. The agreement of a majority of a quorum shall authorize the chairman to act on the issue in question and such action shall be considered at the annual meeting of the Medical Staff.

Officially approved minutes of the Nominating Committee shall be filed in the Medical Staff Office. Minutes shall be available to voting members of the Staff for review. The Nominating Committee report shall be made available to each Active Staff member prior to the date on which the election is to be held.

10.2 TERM OF OFFICE

The term of office of general staff officers is two Medical Staff years. Officers assume office on the first day of the Medical Staff year following their election. An officer elected to fill a vacancy assumes office immediately upon election. Each officer serves until the end of his term and until a successor takes office, unless he sooner resigns or is removed from office.

10.3 ATTAINMENT OF OFFICE

10.3(a) Of President, Vice President and Immediate Past President

The President, Vice President and Immediate Past President attain office by automatic succession. The Immediate Past President succeeds from the President, and the President succeeds from Vice President.

10.4(b) Of Vice President

At the annual meeting of the Medical Staff, the Nominating Committee shall present the name(s) of the nominee(s) for the office of Vice President. At this meeting, additional nominations from the floor may be made. Thereafter, the slate shall be closed.

Election of officers shall take place at the annual meeting of the staff. Election shall be by secret ballot if more than one candidate exists for a given office. A majority vote of all eligible members present at a meeting shall constitute a quorum.

10.4 VACANCIES IN OFFICE

10.4(a) In the Office of President

A vacancy in the office of president is filled by succession of the President Elect. If the unexpired term has six months or more to run, such service by succession is only for the balance of the unexpired term. If the unexpired term has fewer than six months to run, the Vice President both completes the unexpired term and serves an additional term as President.

10.4(b) In the Office of Vice President

A vacancy in the office of Vice President shall be filled by holding a special election for the purpose of electing a new Vice President. This election shall be held within 45 days of the creation of the vacancy to fill the office until the next regular election. At least 30 days prior to the scheduled election date, the Nominating Committee shall meet and select nominees for Medical Staff consideration.

10.4(c) Simultaneous Vacancies

If there should exist, for any reason, simultaneous vacancies in two or more offices, the vacant offices shall be filled as follows:

(1) By the procedures listed in Article 10.4(a-b) to the extent applicable;

(2) In the event the offices of the President and Vice President hall be simultaneously vacant, the offices of the President and Vice President shall then be filled by the Medical Staff in the manner provided by Article 10.4(b).

10.5 ELIGIBILITY FOR REELECTION

A Staff member who has served as President is not eligible again for nomination or election to the office of Vice President until one year has elapsed since he/she held the position of President.

10.6 RESIGNATION AND REMOVAL FROM OFFICE

10.6(a) Resignation

Any general Staff officer may resign at any time by giving written notice to the MEC. Such resignation, which may or may not be made contingent upon formal acceptance, takes effect on the date of receipt or at any later time specified in the letter of resignation.

10.6(b) Removal Process

Removal of a general staff officer may be effected by a two-thirds vote by secret ballot of the members of the Staff present and voting, such vote to be taken at a special meeting called for that purpose. Removal may be initiated by the MEC or by a petition signed by at least one third of the Active Staff members.

10.6(c) Causes for Removal

Permissible bases of removal of a general Staff officer include, without limitation:

(1) failure to perform the duties of the position held in a timely and appropriate manner; or,

(2) failure to continuously satisfy the qualifications for the position.

10.7 DUTIES OF OFFICERS

10.7(a) President

The duties of the President, the chief elected officer of the Medical Staff, are as follows:

(1) to act in coordination and cooperation with the Chief Executive Officer or his/her designee of the Hospital in all matters of mutual concern within the Hospital;

(2) to call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

(3) to chair the MEC, and serve as a nonvoting member of the Hospital Board;

(4) to serve as an ex officio member of all other Medical Staff committees;

(5) to be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, and for implementation of sanctions where they are indicated;

(6) to appoint Medical Staff committee members to all standing, special, and multi-disciplinary Medical Staff committees except the Credentials Committee and the Pharmacy-Therapeutics Committee;

(7) to represent the views, policies, needs, and grievances of the Medical Staff to the Board and to the Chief Executive Officer or his/her designee;

(8) to receive the policies of the Board and interpret them for the Medical Staff;

(9) to be responsible for the educational activities of the Medical Staff;

(10) to speak for the Medical Staff in its external professional and public relations; and

(11) to serve as physician in charge of disaster drill coordination.

10.7(b) Vice President

In the absence of the President, he shall assume all the duties and have the authority of the President. He shall be a member of the MEC. He shall automatically succeed the President Elect when the latter fails to serve for any reason. In addition, the Vice President shall be responsible for:

(1) serving as vice chairman of the Credentials Committee;

(2) serving as chairman of the Peer Review Committee.

10.7(c) Immediate Past President

The duties of the Immediate Past President are as follows:

(1) to serve as a voting member of the Executive Committee; and

(2) may serve as a non-voting member of the Board.

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10.8 CONFLICT OF INTEREST OF MEDICAL STAFF MEMBERS

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

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

Upon being granted appointment to the Medical Staff and/or clinical privileges, and upon any grant of reappointment and/or renewal of clinical privileges, each Medical Staff member shall file with the MEC a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a Medical Staff member, and/or a member of the community, which in any way and to any degree may impact on the finances or

operations of the Hospital or its staff, or the Hospital's relationship to the community, including but not limited to each of the following:

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

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

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

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

In addition to the foregoing, a new Medical Staff leader (defined as any member of the MEC, officer of the Medical Staff, and/or members of the Medical Staff who are also members of the Hospital's Board) shall file the written statement immediately upon being elected or appointed to his/her leadership position. This disclosure requirement is not a punitive process and is only intended to identify those conflicts of interest which may affect patient safety or quality of care. This disclosure requirement is to be construed broadly, and a Medical Staff member should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure requirement will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

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

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

ARTICLE XI
GOVERNING BODY OF THE MEDICAL STAFF

11.1 MEDICAL EXECUTIVE COMMITTEE

The MEC's function, size and composition shall be determined by the organized medical staff and approved by the governing body. The MEC is empowered to act for the Medical Staff as a whole in all matters except as noted in these Bylaws. The authority and functions of the MEC are outlined in Article XII, and additional functions may be delegated or removed through amendment of the Manual. The MEC is composed of all general officers of the staff and other members characterized in Article XII.

ARTICLE XII
COMMITTEES & FUNCTIONS

12.1 FUNCTIONS OF THE STAFF

The required functions of the Medical Staff are those required by law and those specified in these Medical Staff Bylaws and regulations and policies. They shall be accomplished as indicated in the Bylaws, through assignment to the Staff as a whole, to Staff committees, to Staff Officers or other individual Staff members, or to interdisciplinary Hospital committees with participation of Medical Staff members. The required functions of the Medical Staff are as follows:

(a) To govern, direct, and coordinate the Staff organization and its various functions;

(b) To plan, conduct, coordinate, and evaluate the Medical Staff components of the Hospital's quality management program and to continuously strive to improve the quality of patient care;

(c) to conduct, coordinate, and evaluate the effectiveness of monitoring activities, including, blood usage, mortality, antibiotic and other drug use reviews; delinquent medical records; late dictated H&P's; analysis of unexpected clinical occurrences; fulfillment of consultation requirements; and compliance with the Bylaws, rules, regulations, policies and procedures of the Staff and the Hospital;

(d) To conduct, coordinate, and evaluate the effectiveness of the Hospital's utilization review activities;

(e) To conduct, coordinate, and evaluate the effectiveness of special studies of the structures, processes, and outcomes of care;

(f) To monitor and evaluate care provided in and develop clinical policies for patient care and support services;

(g) To conduct, coordinate, and act on credentials investigations and recommendations regarding Staff membership, grants of clinical privileges, corrective action, and specified services for allied health professionals;

(h) To provide and evaluate continuing education opportunities, responsive, when appropriate, to quality assurance program findings and to new state-of-the art developments pertinent to clinical practice in the Hospital;

(i) To plan, conduct, coordinate, and evaluate training of medical students and residents, if applicable;

(j) To develop and review policies and practices on and maintain surveillance over the completeness, timeliness, and clinical pertinence of patient medical and related records;

(k) To develop and maintain surveillance over drug use policies and practices;

(l) To investigate and monitor hospital-acquired infections and participate in the Hospital's infection control program;

(m) To participate in planning for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community;

(n) To direct Staff organizational activities, the review and revision of Staff Bylaws, nomination and/or election of Staff Officers and committee nominations, the liaison with the Board and Hospital Administration, and the review and maintenance of Hospital accreditation; and

(o) To participate in quality improvement activities within clinical areas and other Hospital activities.

12.2 PRINCIPLES GOVERNING COMMITTEES

12.2(a) Medical Executive and Other Committees

There will be a MEC and such other standing and special committees, responsible to the MEC or to a designated Staff official, as are necessary and desirable to perform any of the functions listed in Article 12.1.

12.2(b) Substitution

The MEC may, at any time it deems necessary and desirable for the proper discharge of the functions required of the Staff by the Bylaws and the Bylaws and policies of the Hospital, establish, eliminate, or merge standing or special Staff committees, change the functions of a Staff committee, or assign the function to the Staff as a whole.

12.2(c) Representation on Hospital Committees

Staff functions and responsibilities relating to liaison with the Board and the Hospital Administration, Hospital accreditation, disaster planning, facility and services planning, financial management, and functional and physical plant safety which require participation of, rather than direct oversight by the Staff may be discharged in part by various Officers and organizational components of the Staff as described in the Bylaws and related regulations and policies, and in part by Medical Staff representation on Hospital committees established to perform such functions.

12.2(d) Ex Officio Members

The Chief Executive Officer or his/her designee, as well as the Medical Director, shall be ex officio members of the MEC and of all other standing and special committees of the Staff. In matters related to peer review activities concerning the Medical Staff, ex officio members who are not Medical Staff members are without vote.

12.2(e) Action Through Subcommittees

Any standing committee may elect to perform any of its specifically designated functions by constituting any number of its members as a subcommittee for that purpose, reporting such action to the parent committee and to the MEC in writing. Any such subcommittee may include individuals in addition to members of the standing committee. Such additional members are appointed by the committee chairman after consultation with the Medical Staff President and with the Chief Executive Officer or his/her designee when administrative Staff appointments are to be made.

12.2(f) Term, Prior Removal, and Vacancies

When committees are first appointed under the Bylaws, the appointed members will serve a term of one year.

A voting committee member may not be removed arbitrarily or capriciously by action of the MEC. A vacancy in any committee is filled for the unexpired portion of the term in the same manner in which the original appointment is made. Any ex officio member of the Staff committee ceases to be such if he ceases to hold the designated position which is the basis of ex officio membership.

12.3 CREDENTIALS COMMITTEE

12.3(a) The Credentials Committee shall serve as the hub for credentials and delineation of practice privileges. It shall receive from the Medical Staff written recommendations and completed applications for Staff appointment, reappointment, Staff category assignment, clinical specialty, membership prerogatives, clinical privileges, and corrective actions concerning any of the foregoing. It shall then make recommendations to the MEC to act upon.

12.3(b) Credentials Committee shall consist of the following members as nominated and approved by the Medical Executive Committee:

(1) Credentialing Advisor (the individual who is authorized and empowered by the MEC to act on behalf of the Credentials Committee);

(2) The Chief Executive Officer or his/her designee, who shall serve as an ex officio, voting member of the committee;

(3) The Medical Director, who shall serve as an ex officio, voting member of the committee; and

(4) Members-At-Large as appointed by the Credentialing Advisor.

provided, however, that, notwithstanding any other provision of the Bylaws, no person who is an employee of another hospital shall serve on the Credentials Committee.

12.3(c) Quorum

Those voting members at the meeting shall constitute a quorum.

12.3(d) Meetings

Meetings of the Credentials Committee may be held bi-monthly, as needed, at a time and a place specified by the Credentialing Advisor. Special meetings may be called at the request of the Credentialing Advisor. Notice of such special meetings must be given to all members five (5) days prior to the date of the meeting. On issues of an emergent nature, in lieu of a special meeting, the Credentialing Advisor may poll members of the committee personally, by telephone, or electronically. The agreement of a majority of a quorum shall authorize the Advisor to act on the issue in question and such action shall be reconsidered at the next regular meeting of the Credentials Committee.

12.3(e) Reports

The committee shall report its activities to the MEC on a regular basis.

12.4 MEDICAL EXECUTIVE COMMITTEE

12.4(a) The MEC shall serve as the governing body of the Medical Staff. Medical Staff President is automatically chairman and will preside over the MEC. The MEC shall consist of the following voting members:

(1) Chairman (also serves as Medical Staff President);

(2) Vice Chairman;

(3) The Chief Executive Officer or his/her designee, who shall serve as an ex officio voting member;

(4) The immediate past Medical Executive Committee Chairman shall serve as an ex officio, voting member;

(5) The Medical Director shall serve as ex officio, voting member; and

(6) Members-At-Large; and

provided, however, that, notwithstanding any other provision of these Bylaws, no person who is an employee of another hospital shall serve on the MEC. In the event that any listed committees are chaired by co-chairmen, each such co-chairman shall be entitled to attend MEC meetings, but committee shall be entitled to only one vote.

12.4(b) The MEC shall discharge the following functions:

(1) Recommend, adopt, amend, and repeal all rules and regulations, policies and other documents referenced in the Bylaws, subject to Article XV of the Bylaws;

(2) Coordinate the activities and general policies of the Medical Staff;

(3) Act for the Staff as a whole under such limitations as may be imposed by the Bylaws and Rules and Regulations of the Medical Staff;

(4) Receive and act upon the reports of all standing, special, ad hoc and Hospital committees;

(5) Consider and recommend action to the Chief Executive Officer or his/her designee of the Hospital on all matters of a medico-administrative nature;

(6) Report to the Medical Staff at its annual meeting all principal actions taken in the preceding period;

(7) Inform the Medical Staff of policies and of correspondence with The Joint Commission;

(8) Apprise the Medical Staff of policy and procedural changes through electronic methods or the publication of memoranda, the mailing of which shall constitute an official notification of such policy and procedural change to the Staff members concerned;

(9) Recommend to the Board the acceptance of rejection of applications for initial appointments, the acceptance or rejection of applications for reappointments,

recommendations concerning Staff categories, and clinical privileges of members of the Medical Staff;

(10) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of the Staff members, including but not limited to initiating investigations, pursuing corrective action and affording due process as set forth in the Bylaws;

(11) Perform such other functions as may be authorized by the Bylaws from time to time, or as may be delegated to it from time to time;

(12) Report to the Governing Board and to the Medical Staff regarding the overall quality and efficiency of patient care in the Hospital; and

(13) Review and approve job descriptions submitted by the Administration of the Hospital and/or Credentials Committee detailing specific patient care activities and responsibilities pertaining to allied health professionals assigned to a member of the Medical Staff.

12.4(c) Quorum

Those voting members at the meeting shall constitute a quorum.

12.4(d) Meetings

Meetings of the MEC shall be held bi-monthly as needed at a time and place specified by the Chairman. In the event the attendance is below the quorum or the specified day is a legal holiday, the Chairman shall fix an alternate meeting date. Special meetings may be called at the request of two members of the MEC. Notice of such special meetings must be given to all members five days prior to the date of the meeting. On issues of an emergent nature, in lieu of a special meeting, the chairman may poll the MEC members personally, by telephone, or electronically. The agreement of a majority of a quorum shall authorize the Chairman to act on the issue in question and such action shall be reconsidered at the next regular meeting of the MEC.

12.4(e) Minutes

Officially approved minutes of the MEC meetings shall be filed in the Administration. These minutes shall be available to voting members of the Staff for review.

12.4(f) Removal of MEC Members

The removal process (including reasons for removal) for those members of the MEC who are elected by the Medical Staff shall be the same as described in Article 10.6 with respect to Medical Staff Officers. All other members of the MEC shall be removed in accordance with the provisions governing removal from their respective Medical Staff leadership positions as follows:

(1) Resignation

Any Officer may resign at any time by giving written notice to the MEC. Such resignation, which may or may not be made contingent upon formal acceptance, takes effect on the date of receipt or at any later time specified in the letter or resignation.

(2) Removal Process

Removal of an Officer may be effected by a two-thirds vote by secret ballot of the members of the Staff present and voting, such vote to be taken at a special meeting called for that purpose. Removal may be initiated by the MEC or by a petition signed by at least one third of the Active Staff members.

(3) Causes for Removal

Permissible bases of removal of an Officer include, without limitation:

(A) failure to perform the duties of the position held in a timely and appropriate manner; or

(B) failure to continuously satisfy the qualifications for the position.

12.5 PHARMACY-THERAPEUTICS COMMITTEE (Lutheran Health Network Process)

12.5(a) This committee shall be responsible for the development and surveillance of pharmacy and therapeutics policies and practices, and of all drug utilization policies and practices within the Hospital in order to promote desirable clinical results and reduce the potential for hazard, except for the evaluation and approval of all protocols concerned with the use of investigational or experimental drugs. These policies and procedures shall relate to but not be limited to, selection, network distribution and handling, procurement, storage, use and safety procedures.

The committee shall serve as an advisory group to the MEC. Written reports shall be maintained that reflect results of all evaluations performed and actions taken. The committee shall also advise the Medical Staff and the Pharmacy on matters pertaining to the drugs available for patient care and diagnostic testing, and on additions or deletion of drugs in the Hospital's formulary.

12.5(b) Committee Composition

The committee shall consist of six representatives of the Lutheran Medical Staff, one from each of the following clinical services and/or sections:

(1) Medicine

(2) Surgery

(3) Obstetrics-Gynecology

(4) Family Practice

(5) Anesthesia

(6) Emergency Medicine

The chairman shall be appointed by the President of the Lutheran Medical Staff and the members shall be appointed by the chairmen of the respective services.

The Director of Pharmacy, a clinical pharmacist, and one representative each from Nutritional Services, and Nursing shall also be voting members. The LHI Chief Executive Officer or his designee, as well as the LHI Chief Medical Officer, shall serve as ex officio, voting members of the committee.

The Chief Nursing Officer and one Nurse Manager from Rehabilitation Hospital shall serve as members of this committee.

12.5(c) Meetings and Reports

This committee shall meet at a time and place as designated by the chairman, but not less than quarterly. All minutes and written reports shall be forwarded to the MEC.

12.5(d) Quorum

A quorum shall be defined as those voting members present at the meeting.

12.5(e) Minutes

Officially approved minutes of the Pharmacy-Therapeutics Committee meetings shall be filed in Administration. All minutes and written reports shall be forwarded to the Medical Executive Committee for presentation at the MEC meeting and shall be available to voting members of the Staff for review.

12.6 PHYSICIAN-IN-NEED COMMITTEE

12.6(a) This committee is formed to assure the quality and safety of care provided the Hospital's patients by attempting to identify any instance of suspected functional or professional impairment involving a member of the Medical Staff. This impairment may include, but not be limited to, chemical dependency; or mental, physical or aging problems that have or could give rise to injury to a patient. The Medical Staff in so doing, attempts to fulfill its obligations to its patients; as well as its moral and professional obligations to its colleagues.

12.6(b) Composition

The committee shall be composed of at least three members of the Active Staff appointed by the Medical Staff President. Each member is appointed for two years with no limitation on the number of terms they may serve.

The Chief Executive Officer or his/her designee, as well as the Medical Director, shall serve as ex officio, voting members of the committee.

This committee is established as a peer review committee, entirely independent of any other committee; and shall be entirely separate from any discipline or enforcement activities established or authorized by the Bylaws.

12.6(c) Duties

Should any Medical Staff member, hospital personnel, patient or patient's family express a reasonable concern that a member of the Medical Staff is impaired, the following procedures are recommended:

(1) A written report of the specific concerns and behaviors shall be given to the CEO/designee, Medical Staff President, or chairman of the Physician-In-Need (PIN) Committee. The anonymity of the individual giving the report will be maintained.

(2) If the report raises a concern that a physician may have a problem, the individual receiving the report will interview its author(s). If a concern persists following that interview, the physician involved will also be interviewed.

(3) In the case of the Acutely Impaired Physician:

(a) When hospital personnel, a patient or a patient's family expresses concern that a physician appears acutely impaired, the Chief Nursing Officer or Medical Director must be contacted immediately. If it's determined that the physician is impaired, the CEO or his/her designee will be notified.

(b) The physician in question will be informed of Hospital policy and procedures in suspected impairment and the physician will be requested to wait until the CEO or designee arrives. At that time, the CEO/designee shall accompany the practitioner in question to Lutheran Hospital ED. Every attempt will be made to follow the standard chain-of-custody procedure. The CEO and/or designee will arrange for immediate coverage for the physician's patient(s).

(c) Samples shall be submitted as John Doe to ensure the practitioner's identity is kept confidential;

(d) Should the urine screen and/or blood alcohol be positive, or if the CEO/designee determines the physician to be otherwise psychiatrically and/or physically impaired, the physician in question will be asked to cease patient care until further notice and make temporary arrangements to cover his practice.

(e) All information is to be given to the hospital Physician-In-Need Committee to be reviewed within three business days. The physician in question should be apprised of this review. The Committee shall review all information and interview the physician in question.

(4) If the initial report and/or interviews lack sufficient information to warrant further action initially, they will be kept in the physician's confidential peer review file only to be reconsidered if there is a repeat complaint.

(5) If the reports and interviews however prove substantial, the Physician-In-Need Committee will be convened to review them. If the Committee concurs, it may be recommended to the physician that he/she be interviewed by the Coordinator of the Indiana State Medical Association's Physicians Assistance Program (ISMA-PAP) and that individual will be contacted.

(6) If as a result of that interview the physician is recommended to undergo a formal evaluation by a qualified facility or a qualified physician approved by the ISMA-PAP, the physician must consent to undergo the evaluation and follow the treatment recommendations that result as a condition of continued appointment and clinical privilege at Rehabilitation Hospital.

(7) If treatment is recommended, the physician will sign a contract with ISMA-PAP agreeing to treatment. When treatment is completed, a second long-term contract will be negotiated between ISMA-PAP and the physician which will cover but is not limited to the following:

(a) Periodic random urine screens if appropriate to the impairment;

(b) Attendance at regular Alcoholics/Narcotics Anonymous meetings if appropriate to the impairment;

(c) Attendance at Caduceus meetings appropriate to impairment;

(d) Periodic meetings with an approved physician advocate;

(e) Continued therapy as recommended by the treating physician;

(f) Other items appropriate to the impairment;

(g) Approval to send regular reports to the CEO/designee and Medical Staff President documenting contract compliance.

(8) Failure to comply with the request for evaluation, recommendation for treatment, or the terms of the contract with ISMA-PAP will result in a report to the Executive Committee of the Hospital Medical Staff and possibly the Indiana Medical Licensing Board.

(9) The CEO/designee shall inform the individual who filed the original report that follow-up action was taken.

(10) Treatment and rehabilitation

(a) If treatment or rehabilitation is recommended to the physician, he/she will request a medical leave of absence and discontinue his/her practice in the Hospital voluntarily.

(b) If the physician refuses to discontinue practice voluntarily, his/her privileges will be immediately suspended until treatment and rehabilitation have been accomplished.

(11) Reinstatement

(a) Upon completion of program of treatment and rehabilitation as recommended by the evaluation physician/institution, the CEO/designee, Medical Staff President, and Chairman of Physician-In-Need Committee may consider the physician for resumption of his clinical hospital practice.

(b) In considering an impaired physician for reinstatement, patient care interests must be paramount.

(c) A letter must be obtained from the Physician Director of the treatment/rehabilitation program where the physician was treated verifying that the physician participated in the program, was in compliance with the treatment plan, regularly attended assigned meetings, and to answer the question whether the physician is now in his/her opinion rehabilitated and capable of resuming medical practice and providing continuous competent care to his/her patients.

(d) Periodic reports from the monitoring body (ISMA-PAP) should be reviewed by the Medical Staff President and kept in the physician's confidential peer review file for the duration of his/her contact.

12.6(d) Meetings

The committee shall meet as often as necessary to accomplish its purpose.

Minutes of the activities of the meeting shall not be recorded, and confidentiality will always be respected.

126(e) Policy

The committee shall have no disciplinary powers and will act as the physician's advocate. All contacts or sources of information, to include physicians contacts, shall be held confidential.

ARTICLE XIII
MEETINGS

13.1 ANNUAL STAFF MEETING

For purposes of the business of the Medical Staff, the business year will be the calendar year, commencing on 1 January and expiring on 31 December of that year.

13.2 MEDICAL STAFF MEETINGS

13.2(a) Regular Meetings

An annual Staff meeting may be held each year. Generally, this meeting shall be held in September. The MEC may authorize the holding of additional general meetings by resolution. The resolution should require notice specifying the place, date, and time for the meeting, and specify the agenda for which the meeting is being called.

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

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

(2) Administrative reports from the CEO or his/her designee, the Medical Staff President, and the Medical Director, characterizing the current state of the hospital;

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

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

(5) Other old or new business.

13.2(b) Special Meetings

A special meeting of the Medical Staff may be called by the Medical Staff President, and must be called by the President at the written request of the MEC or fifteen (15%) percent of the members of the Active Staff. A special meeting may also be called by the Chief Executive Officer of the Hospital or his/her designee, who shall provide notice of the place, date, time and subject matter of any such meeting called.

13.2(c) Quorum

Unless otherwise so stipulated, a quorum shall be defined as those voting members present at the meeting.

13.3 ATTENDANCE REQUIREMENTS

13.3(a) General

Attendance requirements at Medical Staff and committee meetings are established by each committee, as approved by the MEC.

13.3(b) Special Appearances or Conferences

A practitioner whose patient's clinical course of treatment is scheduled for discussion at Staff, committee meeting must be notified and invited to present the case.

13.4 NOTICE, QUORUM, MINUTES, ACTION, AGENDA REQUIREMENTS

Notice, quorum, minutes, action, and agenda requirements for meetings shall be as set forth in the rules and regulations of the Staff, except as specifically provided in these Bylaws. In the event of conflicting provisions, these Bylaws shall govern.

Unless otherwise so stipulated, a quorum shall be defined as those voting members present at the meeting.

13.5 MINUTES

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

Complete and detailed minutes must be recorded and maintained.

13.6 ATTENDANCE

13.6(a) Regular Attendance

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

13.6(b) Special Appearance: Cooperation with MEC

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

ARTICLE XIV
GENERAL PROVISIONS

14.1 STAFF RULES & REGULATIONS & POLICIES

Subject to approval by the Board, the Medical Staff shall adopt rules and regulations and policies necessary to implement more specifically the general principles found within these bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each staff member or affiliate in the hospital. The rules and regulations shall be considered a part of these bylaws, except that they may be amended or repealed at any regular meeting at which a quorum present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board. The rules and regulations shall be reviewed at least every two (2) years, and shall be revised as necessary to reflect changes in regulatory requirements, corporate and hospital policies, and current practices with respect to Medical Staff organization and functions.

14.1(a) Notice of Proposed Adoption or Amendment

Where the voting members of the Medical Staff propose to adopt a rule, regulation or policy, or an amendment thereto, they must first communicate the proposal to the MEC.

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

14.1(b) Provisional Adoption by MEC

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

In such cases, the Medical Staff shall be immediately notified by the MEC. The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MEC, the provisional amendment shall stand. If there is conflict over the provisional amendment, the process described in Article 15.1(c) shall be implemented.

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

When conflict arises between the Medical Staff and MEC on issues including, but not limited to, proposals to adopt a rule, regulation or policy or an amendment thereto, a process as outlined within the Medical Staff Policy titled “Conflict Resolution” shall serve as a means by which these groups can recognize and manage such conflict early and with minimal impact on quality of care and patient safety.

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

14.1(d) Final Authority of the Board

The Board shall have final authority regarding the adoption of any rule, regulation or policy or amendment thereto, and (except in the case of a provisional adoption provided for in Section 14.1(b) of this Article) no such rule, regulation or policy or amendment thereto, shall be effective until approved by the Board.

14.2 STAFF DUES

The MEC, with the approval of the Active Staff, will establish the amount and manner of disposition of annual dues. Dues are payable at the beginning of each new Medical Staff year. Failure, unless excused by the MEC for good cause, to render payment within two months of the start of the new Staff year shall, after special notice of the delinquency, result in automatic suspension of Staff membership, including all prerogatives and clinical privileges until the delinquency is remedied. The MEC and organizational components in which the delinquent practitioner holds membership will be notified of the suspension. Medical Staff members who have attained age 65 shall be exempt from the dues obligation.

14.3 PROFESSIONAL LIABILITY INSURANCE

Each practitioner or Allied Health Professional granted clinical privileges in the hospital shall maintain in force professional liability insurance in an amount not less than the current minimum state statutory requirement for participation in the state's Patient Compensation Fund. Such insurance shall be with a carrier reasonably acceptable to the hospital and shall be on an occurrence basis or, if on a claims made basis, the practitioner or AHP shall agree to obtain tail coverage covering his/her practice at the hospital. Each practitioner and AHP shall also inform the Medical Staff Office of the details of such coverage annually. He/she shall also be responsible for advising the MEC and the CEO/designee via the Medical Staff Office of any change in such professional liability coverage.

14.4 FORMS

Application forms and any other prescribed forms required by these bylaws for use in connection with staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports and other matters shall be developed by the CEO or his/her designee, subject to adoption by the Board after considering the advice of the MEC. Such forms shall meet all applicable legal requirements, including non-discrimination requirements.

14.5 CONSTRUCTION OF TERMS & HEADINGS

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

14.6 TRANSMITTAL OF REPORTS

Reports and other information which these bylaws require the Medical Staff to transmit to the Board shall be deemed so transmitted when delivered to the CEO or his/her designee.

14.7 CONFIDENTIALITY & IMMUNITY STIPULATIONS & RELEASES

15.8(a) Reports to be Confidential

Information with respect to any practitioner, including applicants, staff members or AHPs, submitted, collected or prepared by any representative of the hospital including its Board or

Medical Staff, for purposes related to the achievement of quality care or contribution to clinical research shall, to the fullest extent permitted by the law, be confidential and shall not be disseminated beyond those who need to know nor used in any way except as provided herein. Such confidentiality also shall apply to information of like kind provided by third parties.

14.7(b) Release from Liability

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

14.7(c) Action in Good Faith

The representatives of the hospital, including its Board, CEO or his/her designee, administrative employees and Medical Staff shall not be liable to a practitioner or AHP for damages or other relief for any action taken or statement of recommendation made within the scope of such representative's duties.

ARTICLE XV
ADOPTION & AMENDMENT OF BYLAWS

15.1 DEVELOPMENT

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

15.2 ADOPTION, AMENDMENT & REVIEWS

The Bylaws shall be reviewed and revised as needed, but at least every two (2) years. When necessary, the Bylaws and Rules and Regulations will be revised to reflect changes in regulatory requirements, corporate and hospital policies, and current practices with respect to Medical Staff organization and functions.

15.2(a) Medical Staff

These Bylaws may be amended by the affirmative vote of a majority of the Staff members present and voting on such Bylaws, cast at a regular or special Staff meeting at which a quorum is present, provided that a copy of the proposed documents or amendments was given to each Staff member entitled to vote thereon with the notice of the meeting. For amendments required between regular Staff meetings, the proposed amendments shall be distributed by mail, fax, or other forms of electronic transmission to members of the Active Medical Staff. A ballot shall be enclosed with the proposed amendments, which shall be returned to the Medical Staff Office. Voting by proxy shall not be allowed. A voting period not to exceed thirty (30) calendar days from the date of transmission of the proposed amendments shall be established for the return of ballots. In order for proposed amendments to be adopted, there must be a return of ballots representing at least 20% of the Active Medical Staff eligible to vote with a majority vote approving adoption of the amendments. At the discretion of the Medical Executive Committee, an informational meeting may be held during the established voting period. Such amendment shall not be effective until and unless approved by the Board of Trustees. It is the intent of this paragraph that neither the Board nor the Medical Staff shall have the ability to unilaterally amend the Bylaws

15.2(b) Board

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

15.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

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

15.3(a) Appending to these bylaws the approved amendment, which shall be dated and signed by the CEO or his/her designee, the Medical President and the Secretary of the Board; or

15.3(b) Restating the bylaws, incorporating the approved amendments and all prior approved amendments which have been appended to these bylaws since their last restatement, which restated bylaws shall be dated and signed by the CEO, the Medical Staff President and the Secretary of the Board.

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