Covenant
Specialty Hospital

Lubbock, Texas

BYLAWS OF THE MEDICAL STAFF

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PREAMBLE

Covenant Specialty Hospital (the "Hospital") is authorized to do business in the State of Texas to operate a long-term acute care hospital providing care to patients with long term acute care needs. These Bylaws are adopted in order to provide for the organization of the Medical Staff of the Hospital and to provide a framework for self-governance in order to permit the Medical Staff to discharge its responsibilities in matters involving quality patient care, treatment, services, and patient safety, and to provide that the Medical Staff must accept and discharge this responsibility, subject to the ultimate authority of the Board.

Medical Staff Members shall carry out the functions delegated to the Medical Staff by the Board in conformity with these Bylaws.

DEFINITIONS

"Adverse Action" or "Adverse Affect" means reducing, restricting, suspending, revoking, denying or failing to grant or renew Medical Staff membership or Clinical Privileges.

"Allied Health Professional" or "AHP" means an individual, other than a licensed physician, oral surgeon, or dentist who provides direct patient care, treatment, and services at the Hospital under a defined degree of supervision by a Medical Staff Member who maintains Clinical Privileges at the Hospital.

"Appeal" means review of the findings and actions preceding the appeal, by an appellate review panel, following a Hearing if the Hearing decision has an Adverse Affect on the Member.

"Applicant" means a person who has been sent an application for membership to the Medical Staff and who has returned the application completed and signed to the Medical Staff office.

"Board" means the governing board of Covenant Specialty Hospital.

"***Bylaws***" means these Bylaws of the Medical Staff, as they may be amended from time to time.

"***Chief of Staff***" means the Chief of Staff of the Medical Staff, elected by the Members.

"Clinical Privileges" or "Privileges" mean the permission granted to a Member or AHP by the Board, acting upon MEC recommendations, to render specific types of care to patients at the Hospital.

"Excluded Provider" means an individual or entity that will not be reimbursed under a Federal Health Care Program for any item or services furnished, ordered or prescribed.

An individual or entity becomes an Excluded Provider for violations such as program related crimes, patient abuse, claims for excessive charges or unnecessary services, receiving or giving kick-backs, fraud, failing to repay the government for student loans, and/or failing to disclose required information to authorities. The Office of Inspector General, after notice, imposes exclusion upon an individual or entity from all Federal Health Care Programs, not just Medicare and Medicaid. The exclusion exists until the individual or entity has been reinstated by the Office of Inspector General. A Practitioner who chooses not to provide medical care to Federal Health Care Program patients is not an Excluded Provider.

An individual who is under threat of exclusion is also not an Excluded Provider. A sanctioned provider is an individual or entity disciplined for program violations by federal or state agencies, but is not an Excluded Provider. Sanctioning can result from a conviction of one of the above violations or imposition of a civil monetary penalty.

"Fair Hearing Plan" means the procedures for Hearings and Appeals applicable to Members as set forth in Article IX of these Bylaws, as they may be amended from time to time.

"Federal Health Care Program" means Medicare, Medicaid or CHAMPUS or any other federal or state program providing health care benefits which is funded directly or indirectly by the United States government.

"Focused Professional Practice Evaluation" or "FPPE" means a process by which the Medical Staff and Hospital evaluate the Privilege-specific competence of the Practitioner. FPPE is a time-limited period during which the Medical Staff evaluates and determines the Practitioner's professional performance.

"Hearing" means notice of and an opportunity to be heard, in a formal proceeding, with a mechanism for making a verbatim transcript, following an Adverse Action.

"Hospital" means Covenant Specialty Hospital, a long term acute care hospital as defined by 42 CFR §412.23(e).

"Hospital Administrator" means the individual who reports directly to the Board, through whom all administrative authority over the Hospital flows, and who exercises control and surveillance over all administrative activities of the Hospital.

"Investigation" means the focused and purposeful gathering of information, records and other data respecting the competence, professional conduct or practice patterns of a Practitioner for the purpose of determining whether to take or recommend a Professional Review Action. Only the MEC may initiate an Investigation. The routine functioning of the Medical Staff, its committees, and the Hospital's Quality Improvement Office and all discussions with a Practitioner relating to these matters do not constitute an Investigation.

"Medical Executive Committee" or "MEC" means the executive committee of the Medical Staff unless specific reference is made to the executive committee of the

Board.

"Medical Staff" means the formal organization of all Practitioners with Clinical Privileges to attend patients or to provide other diagnostic or therapeutic services at the Hospital and who are named the Medical Staff..

"Medical Staff Member" or "Member" means any physician (doctor of medicine or doctor of osteopathy, or dentist holding a current license to practice within the scope of his or her license who has been appointed as a member of the Medical Staff in accordance with these Bylaws.

"Medical Staff Year" means the calendar year, from January 1 through December 31.

"Non-Member LIP" means a licensed independent practitioner who is not eligible for appointment to the Medical Staff pursuant to these Bylaws. Non-Member LIPs include, but are not limited to podiatrists, psychologists, and orthotists.

"Ongoing Professional Practice Evaluation" or "OPPE" means a process which allows the Hospital and/or the Medical Staff to identify professional practice trends that impact on quality of care, care efficiencies, and patient safety.

"Ownership or Investment Interest" means an equity, debt, or other financial interest in a long term acute care hospital during its development and operation. A direct Ownership or Investment Interest is between the Practitioner and the long term acute care hospital, while an indirect Ownership or Investment Interest is between the long term acute care hospital in question and either (i) the Practitioner's employer, (ii) the Practitioner's spouse, or (iii) any entity in which the Practitioner serves as a director or officer, or in which the Practitioner holds an ownership or investment interest of one percent (1%) or more. Medical staff appointment and/or clinical privileges at a facility do not, in and of themselves, constitute an Ownership or Investment Interest.

"Patient Contact" means an admission, consultation, or procedure.

"Policies" means policies and manuals of the Medical Staff guiding the activities and structure of the Medical Staff, including all policies and procedures related to Medical Staff and AHP credentialing.

"Practitioner" means Applicants, as well as Members, Non-Member LIPs and AHPs who provide services to patients in or under the auspices of the Hospital.

"***Professional Review Action"*** means: (i) an action or recommendation of a Professional Review Body; (ii) which is taken or made in the conduct of a Professional Review Activity; (iii) which is based on the competence or professional conduct of an individual Practitioner that is harmful or potentially harmful to patients; and (iv) where the action or recommendation affects or might Adversely Affect the Clinical Privileges of the Practitioner or, in the case of Members, Medical Staff membership.

"***Professional Review Activity***" means any activity to determine whether a Practitioner

may hold Clinical Privileges at the Hospital or, be appointed to the Medical Staff, to determine the scope of such Clinical Privileges or appointment or to modify such Privileges or appointment.

"***Professional Review Body***" means the Hospital, the Board, or any committee of the Hospital or Board that conducts Professional Review Activities. It includes each committee of the Medical Staff that assists the Hospital or the Board in Professional Review Activities.

"***Provisional Period***" means the period of time in which a Practitioner must successfully complete the FPPE process, which commences on initial grant of Clinical Privileges with the goal of completion within ninety (90) days, unless the MEC designates a longer time frame on granting of Clinical Privileges that in no event should exceed two (2) years, subject to extension, as set forth within these Bylaws.

"***Rules and Regulations***" refers to the Rules and Regulations of the Medical Staff, as may be adopted and amended from time to time pursuant to these Bylaws.

ARTICLE I

PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF AND MEMBERS

1.1 PURPOSES

The purposes of the Medical Staff are to:

a. provide a mechanism for accountability to the Board as to the appropriateness and quality of health care services provided at the Hospital, the qualifications and competence of Practitioners and other individuals exercising Clinical Privileges at the Hospital, and the teaching and research activities at the Hospital;

b. provide for Practitioner education related to patient care and research opportunities directed to the delivery of cost-effective, quality care; and

c. initiate and maintain rules and regulations for self-governance of the Medical Staff, along with the Board's and the Hospital Administrator's oversight and approval; and

d. provide a process and forum for concerns of the Medical Staff and Hospital to be discussed by the Medical Staff with the Board and Hospital Administrator; and

e. assist the Board in fulfilling relevant obligations.

1.2 RESPONSIBILITIES OF THE MEDICAL STAFF

The responsibilities of the Medical Staff are to be fulfilled through the actions of

its Members, officers, and committees, and include:

a. make recommendations to the Board concerning:

(1) participation in long range planning for the Hospital, including the development and implementation of appropriate policies and programs to meet community health needs;

(2) particular services, clinical privileges associated with those services, and the Practitioners to exercise those Clinical Privileges that may be appropriate for patient care within the Hospital;

(3) the appointment of Practitioners to the Medical Staff and the delineation of Clinical Privileges for Practitioners;

(4) the establishment of professional ethics and standards of care and policies and procedures regarding healthcare services furnished within the Hospital to help ensure patient safety and satisfaction;

(5) the list of acceptable specialty board certifications (including without limitation foreign boards) applicable to each Medical Staff category.

b. conduct peer review, quality improvement review, and utilization review on the services of all Practitioners in relation to standards of care the Medical Staff develops and maintains, and to report regularly to the Board concerning the observed quality of care rendered, quality improvement activities, and effective resource utilization by such Practitioners within the Hospital

c. provide continuing education opportunities for Practitioners, stating whether or not certain levels of participation in these activities is required;

d. initiate appropriate corrective action with respect to Practitioners whose services or other conduct are inconsistent with professional ethics, standards of care, these Bylaws, the Rules and Regulations, the Policies or with other policies of the Hospital.

e. assist the Hospital and the Board in meeting its obligations and the policies of the Hospital regarding the provision of uncompensated services for patients unable to pay;

f. develop and enforce, subject to Board approval, these Bylaws, the Rules and Regulations, and the Policies consistent with accepted standards of practice, including requirements regarding the qualifications and practice of Practitioners; and

g. perform such other duties as may be set forth in these Bylaws or actions

in conjunction with the Board.

ARTICLE II

MEDICAL STAFF APPOINTMENT

2.1 NATURE OF MEDICAL STAFF APPOINTMENT

Appointment and reappointment to the Medical Staff is a privilege, not a right, and shall be extended only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment and reappointment of a Member if made by the Board based upon the recommendations of the MEC. No Practitioner may provide patient care services at the Hospital unless he or she is a Member with relevant Privileges, or has otherwise been granted Privileges, as provided in these Bylaws.

2.2 GENERAL CONDITIONS OF MEDICAL STAFF APPOINTMENT AND REAPPOINTMENT.

a. Appointments and reappointments to the Medical Staff are for a period not exceeding two (2) years. Terms of Medical Staff appointment or reappointment begin on the date of approval by the Board after recommendation of the MEC, or such other date as the Board may specify.

b. Medical Staff membership itself confers no Clinical Privileges. Members must also apply for and hold Clinical Privileges in order to perform patient care services at the Hospital.

c. The Board retains the right to modify, suspend or revoke Medical Staff membership or Clinical Privileges in accordance with the provisions of these Bylaws and the Rules and Regulations, or otherwise.

d. Prior to appointment to the Medical Staff, the National Practitioner Data Bank (the "Data Bank") shall be queried. Thereafter, the Data Bank shall be queried every two (2) years in conjunction with the reappointment process.

2.3 QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP

To be qualified for Medical Staff membership, a Practitioner must:

a. Currently hold a valid, unrestricted license to practice his or her profession in the State of Texas that is not subject to any actual or pending restrictions, censures, or conditions that would limit the practice of the Practitioner;

b. Be a graduate of an approved medical, osteopathic, or dental school. If the Practitioner is a graduate of a foreign medical school, the Practitioner must have successfully completed either the ECFMG or FLEX examination;

c. Have successfully completed an approved residency program listed in the "Directory of Residency Programs Accredited by the Accreditation Council for Graduate Medical Education" or an approved American Osteopathic Association (AOA) training program;

d. Be board eligible or board certified by the respective specialty board, recognized by the American Board of Medical Specialties, American Board of Dentistry, American Osteopathic Boards, or American Board of Podiatry Surgery for examination;

e. Currently hold a valid Drug Enforcement Administration (DEA) registration, when applicable to the Practitioner's professional practice. For example, this requirement does not apply to radiologists.

f. Demonstrate documented background, education, training, and experience which shows a continuing ability to provide high quality patient care services at a level of quality and efficiency given the current state of the healing arts and consistent with available resources.

g. Be located (office and residence) within the geographic service area of the Hospital, as defined by the Board, in order to provide timely care for their patients;

h. Maintain adequate professional liability insurance in the minimum amount of $200,000 per occurrence and $600,000 aggregate, or as otherwise required by the Board, and shall furnish the Hospital proof of such compliance, upon the forms as required by the State of Texas;

i. Have a record that is free from current or pending Federal Health Care Program sanctions and not be an Excluded Provider or otherwise ineligible for participation in any Federal Health Care Program, including Medicare, Medicaid;

j. Be free from, or have adequate control over, any physical or mental impairment that would significantly affect his/her ability to practice, including, but not limited to, use or abuse of any type of medicine, substance or chemical that affects cognitive, motor or communication ability in any manner that interferes with, or has reasonable probability of interfering with the qualifications for Medical Staff appointment or Clinical Privileges such that patient care is, or is likely to be, adversely affected;

k. Possess good reputation and character, including good physical health and mental and emotional stability;

l. Possess the ability to work harmoniously with others sufficiently to convince the Hospital that all patients treated by them at the Hospital will receive quality care and that the Hospital and its Medical Staff will be able to operate in an orderly manner;

m. Have a record that is free of any actual or pending criminal convictions, meaning convictions of, pleas of guilty, no contest to, any felony charges; or actual or pending conviction of, pleas of guilty, or no contest to misdemeanor charges in which the underlying allegations involve the practice of a health care profession, Federal Health Care Program fraud or abuse, third party reimbursement, the use of alcohol or controlled substances, crimes of violence or abuse, or crimes of moral turpitude;

n. Meet any additional qualifications set forth elsewhere in these Bylaws or the Rules and Regulations; and

o. Participate in or agree to participate in an Organized Health Care Arrangement ("OHCA") with the Hospital and comply with the policies and procedures of the Hospital relating to the use and disclosure of individually identifiable health information for the purpose of exchanging individually identifiable health information.

2.4 EXCEPTIONS TO QUALIFICATIONS FOR MEDICAL STAFF APPOINTMENT AND REAPPOINTMENT

a. The MEC may recommend to the Board that the board certification/eligibility requirement described in Section 2.3.d be waived for candidates with equivalent qualifications. Practitioners must demonstrate equivalent training and current competence in the defined dimensions of performance.

b. Only the Board may create additional exceptions to the qualifications in the above Section 2.3.d after consultation with the MEC.

2.5 NO ENTITLEMENT TO APPOINTMENT

No Practitioner shall be automatically entitled to appointment or reappointment to the Medical Staff or to the exercise of any particular Clinical Privileges in the Hospital merely by virtue of the fact that such Practitioner (a) is licensed to practice a profession in this or any other state, (b) is a member of any particular professional organization, (c) is certified by any clinical board, (d) has had in the past, or currently has, medical staff appointment or privileges at this or any other hospital or healthcare organization, or (e) resides in the geographic service area of the Hospital as defined by the Board.

2.6 NON-DISCRIMINATION POLICY

The professional criteria for Medical Staff membership and Clinical Privileges shall be applied uniformly to all applicants. Medical Staff membership or particular Clinical Privileges shall not be denied on the basis of age, gender, race, creed, religion, color, national origin, sexual orientation, disability, or any other consideration not impacting the applicant's ability to properly exercise the Clinical Privileges for which he or she has applied.

2.7 ETHICAL DIRECTIVES

All Medical Staff appointees and others exercising Clinical Privileges in the Hospital shall abide by the terms of the Hospital's ethical directives with respect to their practice at the Hospital. No activity prohibited by said directives shall be engaged in by any Medical Staff Member or other Practitioner exercising Clinical Privileges at the Hospital.

2.8 MEDICAL STAFF MEMBER RESPONSIBILITIES

Each Medical Staff Members shall assume such reasonable duties and responsibilities as the Board, or the Medical Staff, shall require from time to time. Such duties and responsibilities include, but are not limited to:

a. Provide his/her patients with care at a generally professionally recognized level of quality and efficiency;

b. Supervise the work of any AHP under his or her direction;

c. Adhere to the ethics of his or her profession, these Bylaws, the Rules and Regulations, the Policies and the standards and ethical principles and policies of the Hospital;

d. Assist the Hospital in fulfilling its responsibilities for providing charitable care;

e. Treat employees, patients, visitors and other Members at the Hospital in a dignified and courteous manner;

f. Prepare and complete medical and other records in a timely manner as defined in these Bylaws, the Rules and Regulations, and applicable Policies.

2.9 PRACTITIONERS WHO HAVE OWNERSHIP OR INVESTMENT INTERESTS WITH OTHER LONG TERM ACUTE CARE HOSPITALS

a. Any Practitioner who has an Ownership or Investment Interest in any long term acute care hospital, other than a facility owned or controlled in whole or in part by St. Joseph Health System or its subsidiaries, which is located within a twenty-five (25) mile radius of the Hospital shall be ineligible for

Medical Staff membership and ineligible to exercise Clinical Privileges at the Hospital.

b. Any Ownership or Investment Interest in another long term acute care hospital shall be disclosed by a Practitioner as part of the Medical Staff application process, and applications for appointment or reappointment from Practitioners who an Ownership or Investment Interest in another long term acute care hospital will not be processed. Refusal to process an application for appointment or reappointment from a Practitioner who has an Ownership or Investment Interest in another long term acute care hospital shall not entitle the Practitioner to a Hearing pursuant to the Fair Hearing Plan. The Chief of Staff or his/her designee shall provide for alternative coverage for the patients of the Practitioner. The wishes of the patients shall be considered where feasible in choosing a substitute Practitioner to the extent necessary to safeguard the patient.

c. A Medical Staff Member shall also be required to disclose to the Board any Ownership or Investment Interest in another long term acute care hospital whenever he or she acquires such Ownership or Investment Interest. The membership and Clinical Privileges of such Practitioners shall automatically terminate upon receipt of said notice by the Board. Automatic termination for this reason shall not entitle the Practitioner to a Hearing pursuant to the Fair Hearing Plan.

d. Failure to accurately disclose any Ownership or Investment Interest in another long term acute care hospital shall result in automatic termination of Medical Staff membership and Clinical Privileges without rights to a Hearing pursuant to the Fair Hearing Plan.

ARTICLE III

CATEGORIES

3.1 THE MEDICAL STAFF

Each Member shall be assigned to a Medical Staff category by the MEC and the Board and such assignment shall be made at the time of initial appointment to the Medical Staff. Changes in Medical Staff category assignment shall be made, ordinarily, only at the time of reappointment to the Medical Staff.

3.2 THE ACTIVE MEDICAL STAFF

a. Qualifications. Active Members are Practitioners who:

i. Meet the basic qualifications for Medical Staff membership set forth in Section 2.3;

ii. Provide at least twelve (12) Patient Contacts per year at the

Hospital. If a Practitioner on the Active Staff fails to provide at least twelve (12) Patient Contacts at the Hospital in a twelve (12) month period, he or she shall automatically be transferred to the Courtesy Staff;

iii. Are able to provide continuous care to their patients; and

iv. Assume all the functions and responsibilities of the Active Staff, including where appropriate, consultation assignments.

b. Prerogatives. Active Members may:

i. Exercise such Clinical Privileges as are granted him or her;

ii. Vote on all matters presented by the Medical Staff or the committee(s) of which he or she is a member;

iii. Hold office and serve on Medical Staff committees; and

iv. Attend all Medical Staff or Hospital education programs.

c. Responsibilities. Active Members must:

i. Contribute to the organizational and administrative affairs of the Medical Staff;

ii. Actively participate as requested or required in activities and functions of the Medical Staff, including qualify/performance improvement and peer review, credentialing, risk and utilization management, medical records completion, monitoring activities, and the discharge of other Medical Staff functions as may be required.

iii. Fulfill any meeting attendance requirements as established by these Bylaws or by action of the MEC.

iv. Fulfill or comply with any applicable Medical Staff or hospital policies or procedures.

v. Pay Medical Staff dues as may be established by action of the MEC from time to time.

3.3 THE COURTESY MEDICAL STAFF

a. Qualifications. Courtesy Members are Practitioners who:

i. Meet the basic qualifications for Medical Staff membership set forth in Section 2.3;

ii. Act only as consultants or have less than twelve (12) Patient Contacts per year at the Hospital (when a Member on the Courtesy Staff has more than twelve (12) Patient Contracts in a year at the Hospital, the Member will automatically be changed to the Active Staff); and

iii. Are members in good standing of the active staff of another health care facility with clinical privileges appropriate to Member's specialty and license in the State of Texas.

b. Prerogatives. Courtesy Members may:

i. Exercise such Clinical Privileges as are granted by the Board;

ii. Not vote on Medical Staff matters;

iii. Sit on Medical Staff committees in a non-voting capacity; and

iv. Not hold Medical Staff office; and

v. Attend Medical Staff meetings (in a non-voting capacity) and Medical Staff or hospital education programs.

c. Responsibilities.

i. Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion, monitoring activities, and the discharge of other Medical Staff functions as may be required;

ii. Fulfill or comply with any applicable Medical Staff or hospital policies or procedures.

iii. Pay Medical Staff dues as may be established by action of the MEC from time to time.

ARTICLE IV

APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

4.1 PRE-APPLICATION PROCESS

a. A prospective Member shall complete in writing the pre-application

questionnaire and submit required supporting documentation as appropriate to allow the Hospital Administrator to make an initial prima facie determination as to whether the prospective Member is eligible to apply for Medical Staff appointment. A determination by the Hospital Administrator that the prospective Member is not eligible to apply for appointment does not Adversely Affect the Member and does not give rise to rights to a Hearing under the Fair Hearing Plan. To be eligible for Medical Staff appointment, the prospective Member must at least:

i. Be licensed to practice in the State of Texas;

ii. Be board eligible or board certified by the respective specialty board, recognized by the American Board of Medical Specialties, American Board of Dentistry, American Osteopathic Boards, or American Board of Podiatry Surgery for examination;;

iii. Have a record that is free from current or pending Federal Health Care Program sanctions, not be an Excluded Provider or otherwise ineligible for participation in any Federal Health Care Program, and not be on the Medicare exclusion list/OIG sanction list; and

iv. Not have an Investment or Ownership Interest in another long term care hospital located within a twenty-five (25) mile radius of Hospital.

b. Those Practitioners who meet the basic criteria for appointment shall be given an application packet.

4.2 APPLICATION FORM

Application for appointment to the Medical Staff shall be in writing, and shall be submitted on forms approved by both the Medical Executive Committee and the Board. These forms shall be obtained by applicants from the Hospital Administrator or designee. The application shall contain a request for Medical Staff category and specific Clinical Privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications including:

a. A current photo ID validating the identity of the applicant;

b. The names and complete addresses of at least three (3) Practitioners, at least one (1) of whom, if possible, is a member of the Active Staff, and at least two (2) of whom must be a peer practicing the same specialty, who have had extensive experience in observing and working with the applicant and who can provide adequate information pertaining to the applicant's present professional competence and character;

c. Names of other hospitals or health care facilities with which the

Practitioner is/was associated, including status and dates and identifying the Chairperson of the Department (if applicable) for which privileges were granted;

d. Information as to whether the applicant's medical staff appointment or clinical privileges have ever been relinquished, denied, revoked, suspended, reduced or not renewed at any other hospital or health care facility, or are currently being investigated at any other hospital or health care facility;

e. Information as to whether the applicant has ever withdrawn his/her application for appointment, reappointment and/or clinical privileges, or resigned from a medical staff before final decision by another hospital's or health care facility's governing board;

f. Information as to whether the applicant's membership in local, state or national professional societies, or license to practice any profession in any state, or Drug Enforcement Administration or controlled substances registration number is or has ever been suspended, modified, terminated, restricted, or is currently being challenged. The submitted application shall include a list or copy of all the applicant's current licenses to practice, as well as copies of Drug Enforcement Administration and other controlled substances registrations (to the extent applicable to the applicant's practice), medical school diploma, and certificates from all postgraduate training programs completed;

g. Evidence of financial responsibility and information on malpractice claims history and experience (suits and settlements made, concluded and pending) during the past ten (10) years, including notice letters, suits actually filed, judgments and the names of present and past insurance carriers;

h. Information concerning any professional misconduct proceedings and any malpractice actions involving the applicant in this State or any other State, including review panel proceedings, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the applicant may deem appropriate;

i. Complete information on the applicant's physical and mental health status, including history of physical and mental illness, and information on conditions presently requiring a physician's care or medication. The applicant must provide information on any health condition that limits or impairs his or her ability to exercise Privileges applied for or to discharge the responsibilities of Medical Staff appointment;

j. Evidence of current professional liability insurance coverage in amounts required by these Bylaws;

k. Information as to whether the applicant has ever been named as a defendant in a criminal action and/or convicted of a crime with details about any such instance; whether any current felony criminal charges are pending against the applicant and whether there have been any past charges, including the details and their resolution;

l. Information on the citizenship and/or visa status of the applicant;

m. The applicant's signature; and

n. Such other information as the MEC or the Board may require.

4.3 APPLICANT AND MEMBER AGREEMENT AND ACKNOWLEDGEMENTS

By applying for and holding Medical Staff membership, an applicant/Member agrees and acknowledges:

a. That he or she will cooperate in the appointment and reappointment process as delineated in these Bylaws and the Rules and Regulations.

b. That he or she has a demonstrated commitment to the treatment of patients suffering from long term conditions or disabilities and pledges to provide continuous care and supervision to all patients within the Hospital for whom he or she is responsible at a generally recognized professional level of quality and efficiency and in compliance with all applicable standards and laws;

c. That he or she has read and agrees to abide by all policies of the Hospital and these Bylaws, the Rules and Regulations, and the Policies, as shall be amended from time to time;

d. That he or she authorizes Hospital representatives to obtain validation of information supplied in support of the application, including interviewing other persons who may have information regarding the applicant's character or professional competence and authorizes such persons to provide such information to the Medical Staff and the Hospital.

e. That he or she agrees to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned;

f. That he or she agrees to provide to the Hospital as it occurs, with or without request, new or updated information that is pertinent to any question on the application form;

g. That he or she is willing to appear for personal interviews in regard to the

application;

h. That he or she releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives in good faith and without malice concerning the applicant's competence, ethics, character, physical and mental health, emotional stability, and other qualifications for Medical Staff appointment and Clinical Privileges;

i. That he or she releases from any liability, the Hospital and all representatives, members of the Medical Staff and any third parties for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials;

j. That he or she agrees that any misrepresentation or misstatement in, or omission from the application, whether intentional or not, shall constitute cause for automatic and immediate rejection of the application resulting in denial of appointment and Clinical Privileges. In the event that an appointment is granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate termination of Medical Staff appointment and Clinical Privileges;

k. That he or she consents to submit to such physical or mental examinations as the MEC or its designee may require by a physician or physicians mutually acceptable to the applicant and the MEC or its designee. In the event of a disagreement concerning the need for an examination or the choice of the examining physician(s), the matter shall be referred to the Board or its designee, whose decision on the matter will be final. Taking or passing a physical or mental examination is not a part of the application process, but the exercise of Clinical Privileges that are otherwise granted may be made subject to the successful completion of such examination(s).

l. That he or she consents to the disclosure of any information regarding the applicant's character or professional competence received by the Medical Staff and the Hospital to the Data Bank, other hospitals, licensing boards, medical associations or similar persons, and releases the Medical Staff and Hospital from any and all liability for so doing.

m. That he or she consents to the sharing among the Medical Staff, Hospital and any other health care providers or entities with which he or she has or is establishing a professional relationship, including, without limitation, other hospitals with which the applicant has applied for medical staff membership or privileges and the applicant's employer, of any information regarding his or her character or professional competence received by the Medical Staff, Hospital or such other health care providers or entities as part of credentialing, quality assessment or peer review processes, and releases the Medical Staff and Hospital from any and all liability for so

doing. Such sharing among the Medical Staff, Hospital and other health care providers is permitted at any time during the course of the applicant's relationship with the Hospital, including at and between appointment and reappointment.

n. That he or she will treat employees, patients, visitors and other Medical Staff members in a dignified and courteous manner.

o. That he or she agrees to participate in peer review and keep all peer review matters confidential.

p. That he or she agrees to refrain from illegal fee splitting or other inducements relating to patient referral;

q. That he or she agrees to refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;

r. That he or she agrees to refrain from deceiving patients as to the identity of any individual providing treatment or services;

s. That he or she agrees to seek consultation whenever appropriate;

t. That he or she agrees to abide by generally recognized ethical principles applicable to the Applicant's profession.

4.4 BURDEN OF PROVIDING INFORMATION

a. In all matters pertaining to any application for Medical Staff appointment or reappointment or for Clinical Privileges, the applicant shall have the burden of producing any information requested by the MEC or the Board relating to his or her application.

b. Until the applicant has provided all information requested by the Hospital, the application for appointment or reappointment will be deemed incomplete and will not be further processed. Should information provided in the initial application for appointment change during the course of an appointment year, the appointee has the burden to provide information about such change to the MEC sufficient for the MEC's review and assessment.

4.5 INCOMPLETE OR MISREPRESENTED INFORMATION

Material misstatements, false statements, inaccurate or incomplete applications, and omissions or misleading statements are grounds for denial of an application or reapplication, without the applicant being entitled to a Hearing under the Fair Hearing

Plan. Failure to update information in the application or upon reapplication will also render an application or reapplication inaccurate, misleading or false and may also be the basis for terminating the application process. Failure to provide any information requested by the MEC or Board during the application or reapplication process within ninety (90) days of the request shall render an application incomplete and null and void with no rights to a Hearing under the Fair Hearing Plan. In the event the application process is terminated and/or an application deemed null and void for any of the reasons set forth in this Section, the applicant shall be notified in writing and appropriate documentation of the notification and supporting information shall be maintained.

4.6 INITIAL APPOINTMENT APPLICATION PROCESSING

a. The application for Medical Staff appointment and all required information shall be submitted by the applicant to the Hospital Administrator or designee. The Hospital Administrator or designee shall collect and verify information and timely review the applicant's application and all required information. Such information may be collected from other Covenant Health System facilities. After reviewing the application to determine that all questions have been answered, and after reviewing all references and other information or materials deemed pertinent, and after verifying the information provided in the application with the primary sources, the Hospital Administrator or designee shall deem the application to be "complete." The timelines and schedule set forth herein are guidelines only and do not create any rights for an applicant to have an application processed within a particular time.

b. When the application has been deemed complete by the Hospital Administrator or designee, the application shall be forwarded to the MEC and reviewed and acted upon at its next regularly scheduled meeting.

    i. As part of the process of making its recommendations, the MEC may require a physical and/or mental examination of the applicant by one or more healthcare providers satisfactory to the MEC and shall require that the results be made available for its consideration. Failure of an applicant to procure such an examination within a reasonable time after being requested to do so in writing by the MEC shall constitute a voluntary withdrawal of the application for appointment and Clinical Privileges, and all processing of the application shall cease.

    ii. Any Member shall have the right to appear in person before the MEC to discuss in private, and in confidence, any concerns the appointee may have about the applicant.

    iii. The MEC shall have the right to require the applicant to meet with it to discuss any aspect of the applicant's application, qualifications, or Clinical Privileges requested.

iv. The MEC may use the expertise of any Member or outside consultant, if additional research is required into the applicant's qualifications.

v. If, after reviewing all required and requested information, the MEC recommends appointment of the applicant to the Medical Staff, the recommendation to appoint must specifically recommend the Clinical Privileges to be granted, which may be qualified by any probationary or other conditions or restrictions.

vi. If the recommendation of the MEC is takes longer than is usual and customary, the Chief of Staff shall send a letter to the applicant, with a copy to the Hospital Administrator, explaining the reasons for the delay.

c. The MEC shall forward its recommendation to the Board. The MEC shall make one of three recommendations: (i) that the applicant be appointed to the Medical Staff, (ii) that the application be deferred for further consideration, or (iii) that the application for Medical Staff appointment or Clinical Privileges be denied.

i. If the recommendation of the MEC is to approve the appointment, it shall transmit its recommendation through the Hospital Administrator to the Board (and/or its committee). All recommendations for appointment must also specifically recommend the Clinical Privileges to be granted, which may be qualified by any probationary or other conditions or restrictions relating to such Clinical Privileges.

ii. If the recommendation of the MEC is to defer the application for further consideration because further investigation and information is required, a subsequent recommendation to the Board must be made prior to the next scheduled Board meeting, through the Hospital Administrator.

iii. If the recommendation of the MEC is an Adverse Action and would entitle the applicant to request a Hearing pursuant to the Fair Hearing Plan, the recommendation shall be forwarded to the Hospital Administrator who shall promptly so notify the applicant in writing, by certified mail, return receipt requested. The MEC has the right to offer an interview with the applicant prior to this or any action. The Hospital Administrator shall then hold the application until after the applicant has exercised or has waived his or her right to a Hearing, after which the Hospital Administrator shall forward the recommendation of the MEC, together with the complete application and all supporting documentation, to the Board (and/or its committee).

d. Upon receipt of the MEC's recommendation, the Board shall act as soon as is practical at its next scheduled regular meeting (or the meeting following the applicant's exercise or right to his or her Hearing rights if the recommendation is an Adverse Action). In its discretion, the Board may defer action for a specified period of time, during which time it may refer the matter back to the MEC for specified further action, or seek advice from the Hospital Administrator, legal counsel, or others on matters of concern. The Board's decision shall be final and conclusive, except that if the MEC's recommendation is one for which the applicant could not request a Hearing, and the Board's decision is contrary to the MEC's recommendation and is one for which the applicant has Hearing rights pursuant to the Fair Hearing Plan, the Hospital Administrator shall notify the applicant and the applicant shall have thirty (30) days in which to request a Hearing. A decision of the Board shall constitute a Professional Review Action and if the decision Adversely Affects the applicant, may entitle the applicant to Hearing rights pursuant to the Fair Hearing Plan. The applicant, the Chief of Staff and the MEC will be promptly notified of the decision of the Board.

4.7 REAPPOINTMENT

a. Each Practitioner who desires Reappointment/renewal of Clinical Privileges shall, at least ninety (90) days prior to the expiration date of the Practitioner's current appointment submit a completed application for reappointment/renewal of Privileges on the application form approved by the Board. Along with the application for reappointment, the Member shall submit the application fee, if required. Failure to submit an application for reappointment/renewal of Privileges by that time will result in automatic expiration of the Practitioner's appointment and Clinical Privileges at the end of the then current Medical Staff year. A Practitioner whose Medical Staff Appointment and Clinical Privileges are so terminated shall not be entitled to any Hearing rights under the Fair Hearing Plan, but rather shall reapply for appointment to the Medical Staff and Clinical Privileges using the application process for initial appointment and Privileges, which shall include the payment of all relevant Medical Staff application fees or penalties, if required.

b. Reappointment and/or renewal of Privileges, if granted by the Board, shall be for a period of not more than two (2) years. If an application for reappointment/renewal of Privileges is filed and the Board has not acted on it prior to the expiration of the appointee's current term of appointment or Privileges, that appointment and Privileges shall continue in effect until such time as the Board acts on the application.

c. Each recommendation concerning reappointment/renewal of Privileges shall be based upon such Practitioner's:

i. Ethical behavior, clinical competence and clinical judgment in the treatment of patients;

ii. Attendance at Medical Staff and committee meetings, and participation in staff duties;

iii. Compliance with the Hospital Bylaws and policies and with these Bylaws, the Rules and Regulations, and the Policies;

iv. Behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of the Hospital, and general attitude toward patients, the Hospital and its personnel;

v. Physical, mental and emotional health;

vi. Capacity to satisfactorily treat patients as indicated by the results of the Hospital's quality assessment activities or other reasonable indicators of continuing qualifications;

vii. Satisfactory completion of such continuing education focusing on improvement activities and changes to clinical practice, evaluation, and patient care review, or any requirements as may be imposed by law, this hospital or applicable accreditation agencies;

viii. Current licensure, including currently pending challenges to any licensure or registration;

ix. Voluntary, involuntary or pending suspension or termination of Medical Staff appointment or voluntary or involuntary limitations, reduction, or loss of clinical privileges at another hospital; and

x. Whether the Practitioner has been excluded from any Federal Health Care Program;

xi. Whether the Practitioner has been convicted of or pled guilty to any felony crime; and

xii. Other reasonable indicators of continuing qualifications and relevant findings from the Hospital's quality assessment activities.

d. Procedure for Processing Applications for Reappointment/Renewal of Privileges. An application for reappointment/renewal of Clinical Privileges shall be evaluated and processed in the same manner and in accordance with the same timelines as an application for initial appointment/Privileges. An application for reappointment/renewal of Privileges will be reviewed against the backdrop of the Applicant's actual performance at the Hospital during the current term as well as information collected from the applicant

and outside sources. Matters and events which did not result in an Adverse Affect during the current term can nevertheless be relevant or determinative in the reappointment/renewal of Privileges process. Matters and events from an earlier term of appointment are relevant if they help demonstrate a pattern or explain matters and events from a current term.

ARTICLE V

CLINICAL PRIVILEGES

5.1 GENERAL

a. Medical Staff appointment or reappointment as such shall not confer any Clinical Privileges or right to practice at the hospital. Each Member shall be entitled to exercise only those Clinical Privileges specifically granted by the Board. Regardless of the level of Privileges granted, each Practitioner must obtain consultation when necessary for the safety of his/her patient or when required by the Rules and Regulations or Policies.

b. The granting of Clinical Privileges shall carry with it acceptance of the responsibilities of such Privileges and Privileges shall be voluntarily relinquished only in the manner that provides for the orderly transfer of such obligations.

c. The Clinical Privileges granted to a Member shall be based upon consideration of the following:

i. The applicant's education, training, experience, demonstrated current competence and judgment, references, and health status;

ii. Availability of qualified physicians or other appropriate appointees to provide medical coverage for the applicant in case of the applicant's illness or unavailability;

iii. Whether the applicant has ever been excluded from participation in any Federal Health Care Program;

iv. The Hospital's available resources and personnel;

v. Any previously successful or currently pending challenges to any licensure or registration, or the voluntary relinquishment of such licensure or registration;

vi. Information concerning any voluntary or involuntary suspension or termination of medical staff appointment or voluntary or involuntary limitations, reduction, or loss of clinical privileges at another hospital; and

vii. Other relevant information, as determined by the MEC and the Board.

d. The applicant shall have the burden of establishing qualifications for and competence to exercise the Clinical Privileges requested.

5.2 MEDICO-ADMINISTRATIVE PHYSICIANS

Any Member who is employed by the Hospital in a medico-administrative position, who is also an appointee to the Medical Staff, shall not automatically experience a loss of Medical Staff appointment and Clinical Privileges in the event that administrative duties are terminated. Only Privileges associated with an exclusive arrangement would automatically terminate.

5.3 TEMPORARY CLINICAL PRIVILEGES

a. Circumstances. Temporary Privileges are available to Practitioners subject to requirements in these Bylaws and the Rules and Regulations in only the following two (2) circumstances:

i. The Practitioner has filed an application for Medical Staff appointment and is awaiting review and approval of the MEC and/or the Board and the Practitioner meets the qualifications set forth in these Bylaws for Medical Staff appointment, verified as described in Section 5.3.d below; or

ii. The Practitioner has not applied for Medical Staff appointment but is necessary to fill an important patient care need as determined on a case-by-case basis by the MEC, Chief Medical Officer, Chief of Staff and the Board and meets the qualifications set forth in these Bylaws for Medical Staff appointment, verified as described in Section 5.3.e below.

b. Duration of Temporary Privileges. Temporary Privileges are granted for no more than one hundred twenty (120) days.

c. Application for Temporary Privileges. Each applicant for Temporary Privileges, including those who do not seek Medical Staff appointment, must receive and review a copy of these Bylaws, the Rules and Regulations, and the Policies applicable to the Clinical Privileges sought and agree to abide by them. In addition, applicants must:

i. Request Temporary Privileges on the form approved by the MEC for that purpose.

ii. Affirmatively demonstrate special circumstances to justify the award of Temporary Privileges without undergoing complete review

of the appropriate Medical Staff application; and

iii. Have in the file a current Data Bank report, which has been obtained and evaluated by appropriate staff.

d. Processing of Temporary Privileges for New Applications for Appointment. Requests for Temporary Privileges are processed in the same manner as Medical Staff applications except as otherwise provided in these Bylaws.

e. Processing of Temporary Privileges to Meet an Important Care Need. When Temporary Privileges are requested to meet an important patient care need, the Hospital Administrator or designee, upon the recommendation of the Chief of Staff, may immediately authorize the Practitioner to exercise the Privileges requested after verification of the following:

i. Current licensure to practice in the State of Texas;

ii. Current and valid DEA registration, as applicable;

iii. Professional liability insurance in limits not less than the minimum amount specified by the Board, which covers the exercise of the Privileges requested;

iv. The applicant is not and has not been excluded or threatened to be excluded from any Federal Health Care Program;

v. A current Data Bank report evaluated and deemed acceptable by appropriate staff;

vi. The applicant possesses, based upon information reasonably available under the circumstances, the qualifications, current competence, relevant training, and abilities and judgment necessary to exercise the requested Privileges; and

vii. The applicant affirmatively demonstrates special circumstances to justify the award of Temporary Privileges to meet an important patient care need and to expedite the credentialing process.

f. Standards for Approval for an Applicant Seeking Medical Staff Appointment. The Hospital Administrator or designee, upon the recommendation of the Chief of Staff (or their designees), may grant a request for Temporary Privileges if the applicant meets the qualifications set forth in these Bylaws. Prior to granting Temporary Privileges, it must be verified that the applicant:

i. Meets all of the qualifications set forth in Section 5.3.e;

ii. Has no current or previously successful challenge to licensure or DEA registration;

iii. Has not been subject to any involuntary limitation, reduction, denial, restriction, termination, relinquishment, or loss of clinical privileges or medical staff membership at any health care facility;

iv. Affirmatively demonstrates special circumstances to justify the award of Temporary Privileges and to expedite the credentialing process.

g. Procedure After Award. After Temporary Privileges are granted, the Board must ratify their award at its next regularly scheduled meeting in order for the Practitioner to continue exercising the Temporary Privileges. A grant of Temporary Privileges is a courtesy and does not ensure ratification of an award of Medical Staff appointment or regular Clinical Privileges.

h. Temporary Privileges shall automatically terminate at the end of the designated timeframe unless earlier resigned or not ratified by the Board, as set forth in this Section, or terminated, suspended, renewed, or extended in accordance with these Bylaws, but under no circumstance shall the timeframe of any grant, renewal, or extension of Temporary Privileges exceed one hundred twenty (120) total days.

i. Denial or Termination. The Hospital Administrator may, upon consultation with the Chief of Staff, deny, modify or terminate Temporary Privileges. The patients of the Practitioner whose Temporary Privileges were denied, modified, or terminated shall be consulted, to the extent feasible, for the choice of a replacement Practitioner. Termination of Temporary Privileges will be effective as of the date of discharge from the Hospital of the Practitioner's patient(s) then under his or her care in the Hospital, if there is no other Active Staff Member who is qualified to continue to treat the patient.

j. Hearing Rights. Denials, modifications, or terminations of Temporary Privileges are deemed not to relate to the Practitioner's professional competence or conduct, unless otherwise specified as relating to such, and do not entitle him or her to a Hearing under the Fair Hearing Plan. Grounds for denying, modifying, or terminating Temporary Privileges not entitling a Practitioner to a Hearing under the Fair Hearing Plan include, but are not limited to:

i. The Practitioner's failure to bear the burden of providing sufficient, accurate, and complete information regarding his or her licensure, DEA registration, non-excluded status, Data Bank report, insurance or competence;

ii. The Practitioner's failure to establish special circumstances; and

iii. The available information is insufficient under the circumstances to allow or continue to allow the Practitioner to exercise the requested Privileges.

Denials, modifications, or terminations that expressly relate to a Practitioner's competence or professional conduct entitle the Practitioner to a Hearing under the Fair Hearing Plan.

5.4 EMERGENCY CLINICAL PRIVILEGES

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

b. In an emergency, a Practitioner who is not currently appointed to the Medical Staff may be permitted by the Hospital to exercise Clinical Privileges to the degree permitted by his/her license and shall be permitted to do and shall be assisted by Hospital personnel in doing everything possible to save the life of a patient or to save a patient from serious harm.

c. Similarly, in an emergency, a Practitioner currently appointed to the Medical Staff may be permitted by the Hospital to act in such emergency by exercising Clinical Privileges not specifically granted to that appointee.

d. A Practitioner exercising Emergency Privileges is obligated to summon all consultative assistance deemed necessary and to arrange for appropriate follow-up by Members with appropriate Privileges.

e. The exercise of Emergency Privileges under this section shall not be considered exercising Clinical Privileges, but rather the right and authority is exclusively for the benefit of the patient.

5.5 PROCEDURE FOR REQUESTING AN INCREASE IN CLINICAL PRIVILEGES

a. Application for Increased Clinical Privileges. Whenever, during the term of appointment to the Medical Staff, increased Clinical Privileges are desired, the appointee requesting increased Privileges shall apply in writing to the Hospital Administrator on a form approved by the Board. The application shall state in detail the specific additional Clinical Privileges desired and the appointee's relevant recent training and experience which justify increased Privileges. The Hospital Administrator shall transmit the application to the Chief of Staff. Thereafter, it will be processed in the same manner as an application for initial Clinical Privileges if the request is made during the term of appointment or is a

part of the reappointment application if the request is made at that time.

b. Factors to be Considered. Recommendations for an increase in Clinical Privileges made to the Board shall be based upon:

i. relevant recent training;

ii. observation of patient care provided;

iii. review of the records of patients treated in the Hospital or other hospitals;

iv. results of the Hospital's quality assessment activities; and

v. other reasonable indicators of the Practitioner's qualifications for the privileges in question.

The recommendation for such increased privileges may carry with it such requirements for supervision or consultation or other conditions, for such periods of time as are thought necessary.

5.6 REVIEW OF CLINICAL PRIVILEGES

a. All initially requested Clinical Privileges, by a current Member or an initial Applicant shall be subject to a period of FPPE. The MEC will recommend an individualized evaluation plan pursuant to the FPPE Policy. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, the tracking of performance monitors indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other health care individuals involved in the care of each patient.

b. The FPPE for newly requested Privileges and newly appointed Members shall be completed within the Provisional Period or within another timeframe established by the MEC. The period of FPPE may be extended for up to twelve (12) months if, upon recommendation by the MEC, further observation of the Practitioner's performance and clinical competence is necessary. The Practitioner shall be informed of the need for further observation and any conditions of such observation. If, at the end of the extension period, the Practitioner has not satisfied the requirements, one of the following two sections will apply:

i. The Practitioner's appointment and/or Clinical Privileges subject to FPPE will be considered voluntarily relinquished if there is insufficient clinical experience for satisfactory completion of the FPPE. Upon receipt of notification of voluntary relinquishment due to insufficient clinical experience, the Practitioner shall be given an opportunity to request, within thirty (30) days, a meeting with the

MEC and the Hospital Administrator or designee. At that meeting, which is in lieu of a Hearing pursuant to the Fair Hearing Plan, the Practitioner shall have an opportunity to explain or discuss extenuating circumstances involving his or her failure to provide sufficient clinical experience for a satisfactory evaluation. At that meeting, none of the parties shall be represented by counsel; minutes shall be kept; the Practitioner may present evidence of extenuating circumstances and why the minimum requirement should be waived or the Provisional Period extended; any party may ask questions of any other party relative to FPPE and the Provisional Period. At the conclusion of the meeting, or if a meeting is not held, the MEC shall make a written report and recommendation to the Board for final action; or

ii. The Provisional Period may be extended for one (1) additional term of twelve (12) months, for good cause by the MEC, if further observation of the Practitioner's performance and clinical competence is necessary. Any such extensions may be reported to the Board. If at the end of the extension, if performance is not satisfactory to the MEC determines that a Practitioner's FPPE performance is not satisfactory, then the MEC may recommend to the Board that the Practitioner's Medical Staff appointment, Clinical Privileges, or a specific Clinical Privilege (as applicable, depending upon the reason for the extension), will be terminated or revoked.

c. Each recommendation concerning the Medical Staff appointment of a Practitioner completing FPPE in the Provisional Period shall include a written evaluation completed by any assigned proctor or preceptor, if applicable, and the MEC consisting of overall clinical competence and clinical judgment in the treatment of patients. If there is a recommendation by the MEC to terminate the Practitioner's appointment and/or Privileges following the Provisional Period based on the written evaluation completed by the assigned proctor or preceptor, the Hospital Administrator or designee shall give the appointee notice of the recommendation. In such instances, the Practitioner shall be entitled to a Hearing pursuant to the Fair Hearing Plan.

d. The Medical Staff will also engage in OPPE in order to identify professional practice trends that impact on quality of care and patient safety. Information from the OPPE will be factored into the decision to maintain existing Clinical Privileges, to revise existing Clinical Privileges, or to revoke an existing Clinical Privilege prior to or at the time of a Member's Medical Staff reappointment. The OPPE shall be undertaken as part of the Medical Staff's evaluation, measurement, and improvement of a Practitioner's current clinical competency. In addition, each Practitioner may be subject to an FPPE when issues affecting the provision of safe, high quality patient care are identified through the OPPE. Decisions to assign a Practitioner to a period of performance

monitoring or evaluation to further assess current competence must be based on the evaluation of a Practitioner's current clinical competence, practice behavior, and ability to perform a specific Clinical Privilege.

ARTICLE VI
ALLIED HEALTH PROFESSIONALS AND NON-MEMBER LICENSED INDEPENDENT PRACTITIONERS

6.1 DEFINED

a. An Allied Health Professional is a Practitioner who functions under the supervision of, whether or not in the employment of, a Member with relevant Clinical Privileges at the Hospital. Any AHP must be supervised by or practice in collaboration with a Member that has Active Staff appointment at the Hospital and must reside and practice within the Hospital's geographic service area, as determined by the Board. The Member sponsor of an AHP (other than Hospital-employed AHPs) assumes responsibility for the AHP's clinical activities.

b. Non-Member LIPs are those Practitioners who are not eligible for Medical Staff membership because they are not a physician or dentist but who are not required to function under the supervision of or in collaboration with a Member. Non-Member LIPs include, but are not limited to, podiatrists, psychologists, and orthotists.

c. In accordance with the Rules and Regulations, AHPs who are employed by the Hospital are subject to the requirements and regulations of their employment and are not subject to these Bylaws and the Rules and Regulations.

d. All categories of medical or surgical assistants ((e.g., medical assistants, registered nurses, etc.) must be processed by the Hospital's Human Resources department.

6.2 AHP QUALIFICATIONS

All AHPs subject to these Bylaws must:

a. Maintain a current license, certificate or other approvals in good standing to practice a health care profession or related service in the State of Texas;

b. Never have had clinical privileges or scope of practice denied, revoked, resigned, relinquished, or terminated by any health care facility, health plan, or other entity for reasons related to clinical competence or professional conduct;

c. Possess the necessary experience, background, training, professional ability and physical and mental health to provide quality care to the patients he or she serves;

d. Be sponsored, supervised and directed by a Member on the Active Staff, and document such relationship to the satisfaction of Hospital;

e. Adhere strictly to the ethics of his or her profession;

f. Practice in such a manner that his or her activities do not interfere with the orderly and efficient rendering of services by the Hospital or by Members; work cooperatively and harmoniously with others in the Hospital setting; be willing to participate in and properly discharge AHP staff responsibilities; and commit to and regularly assist the Hospital in fulfilling its obligations related to patient care, within the areas of their professional competence;

g. Be willing to participate in the discharge of other responsibilities at the request of the Chief of Staff or the Hospital Administrator or designee;

h. Maintain in force and effect professional liability insurance in amounts established by the Board with a carrier reasonably acceptable to the Hospital; and

i. Not be excluded from any Federal Health Care Program.

6.3 NON-MEMBER LIP QUALIFICATIONS

All Non-Member LIPs subject to these Bylaws must:

a. Maintain a license, certificate or other approvals in good standing to practice a health care profession or related service in the State of Texas;

b. Never have had clinical privileges or scope of practice denied, revoked, resigned, relinquished, or terminated by any health care facility, health plan, or other entity for reasons related to clinical competence or professional conduct;

c. Never have been convicted of, or entered a plea of guilty or no contest to any misdemeanor relating to controlled substances, illegal drugs, insurance fraud or abuse or violence or to any felony.

d. Possess the necessary experience, background, training, professional ability and physical and mental health to provide quality care to the patients he or she serves;

e. Adhere strictly to the ethics of his or her profession;

f. Practice in such a manner that his or her activities do not interfere with the orderly and efficient rendering of services by the Hospital or by Members;

g. Be willing to participate in the discharge of other responsibilities at the request of the Chief of Staff or the Hospital Administrator;

h. Maintain in force and effect professional liability insurance in amounts established by the Board with a carrier reasonably acceptable to the Hospital; and

i. Not be excluded from any Federal Health Care Program.

6.4 PROCEDURE FOR SPECIFICATION OF SERVICES

Applications for specified services for AHPs and Non-Member LIPs shall be submitted and processed in the same manner as provided in Section 6 for Clinical Privileges of Members. Every AHP or Non-Member LIP applying for Clinical Privileges agrees to be bound by the conditions of appointment and the confidentiality, immunity and release provisions set forth in these Bylaws, as such provisions apply to AHPs and Non-Member LIPs. Each AHP and Non-Member LIP grant of Clinical Privileges shall be for a term not to exceed two (2) years.

6.5 TERMINATION OF AHP PRIVILEGES

a. Automatic Termination. An AHP's Privileges shall automatically terminate, without right of review, in the event:

   i. The appointment, contract or related Privileges of the supervising or collaborating Member is suspended or terminated, whether such suspension or termination is voluntary or involuntary;

   ii. The supervising or collaborating Member no longer agrees to act as the supervising or collaborating Member for any reason, or the relationship between the AHP and the supervising Member, if any, is otherwise terminated, regardless of the reason therefore;

   iii. The AHP's license or certification to practice expires, is revoked, or is suspended; or

   iv. The AHP fails to maintain the required professional liability insurance.

b. Action by the Chief of Staff. The AHP's Privileges may also be limited, suspended, or terminated for other reasons by the Chief of Staff, subject to the review procedure set forth in Section 6.7.

6.6 TERMINATION OF NON-MEMBER LIP PRIVILEGES

a. Automatic Termination. A Non-Member LIP's Privileges shall automatically terminate, without right of review, in the event:

i. The contract between the Hospital and the Non-Member LIP for the provision of specified services terminates;

ii. The Non-Member LIP's license or certification to practice expires, is revoked, or is suspended; or

iii. The Non-Member LIP fails to maintain the required professional liability insurance.

b. Action by the Chief of Staff. The Non-Member LIP's Privileges may also be limited, suspended, or terminated for other reasons by the Chief of Staff, subject to the review procedure set forth in Section 6.7.

6.7 AHP AND NON-MEMBER LIP PRIVILEGE REVIEW PROCESS

a. AHPs and Non-Member LIPs shall not be entitled to Hearing rights under the Fair Hearing Plan, but rather an AHP or Non-Member LIP may appear on his or her own behalf (for reasons other than for automatic termination as specified in Sections 6.5 and 6.6) within fifteen (15) days of receiving notice of such action:

i. Before the MEC to discuss any disagreement about the MEC's recommendation regarding requested Clinical Privileges; and

ii. Before the Board or relevant committee thereof to discuss a Board decision to terminate the Clinical Privilege of the AHP or Non-Member LIP.

b. Neither of such appearances shall constitute a Hearing or be conducted as such pursuant to the Fair Hearing Plan. Before such appearances, the affected AHP or Non-Member LIP shall be informed of the reasons for the action or proposed action and at the appearance the AHP or Non-Member LIP may present information relevant thereto. A report of the findings and recommendations following the appearances shall be made by the Chief of Staff to the MEC and the Board. The Board shall consider the recommendation of the MEC and the Board's decision shall be final.

6.8 SUPERVISING OR COLLABORATING MEMBERS

Suspension, termination or curtailment of the Privileges of an AHP with whom a Member has a collaborative practice or supervision agreement shall not be deemed to adversely affect the Privileges of the Member and shall not trigger Hearing rights under the Fair Hearing Plan on behalf of the Member. The supervising or collaborating Member is responsible for the care rendered by the AHP in such instances.

ARTICLE VII

INVESTIGATIONS AND CORRECTIVE ACTION

7.1 SELF-REPORTING OF IMPAIRED MEMBERS.

a. All Practitioners must ensure that quality, safe care is delivered to Hospital patients. Any suspicion of impairment shall be reported immediately. For purposes of these Bylaws, "impaired" or "impairment" is defined as being unable to practice medicine or provide services within a Practitioner's scope of practice with reasonable skill and competency, and/or an inability to function safely and effectively because of physical or mental illness, including deterioration through the aging process or loss of motor skills, or the use or abuse of alcohol, drugs, or other mind altering substances.

b. At any time, if a Member feels that he or she may have an impairment, he or she may self-refer to an appropriate professional for either internal or external resources to diagnose and/or treat the condition of concern. Any self-referral for diagnosis and/or treatment for impairment shall be reported to the Chief of Staff, MEC, or Hospital Administrator by the Practitioner.

c. An individual, or the MEC, who suspects a Practitioner of being impaired must give an oral or, preferably, a written report to the Hospital Administrator or the Chief of Staff. The report must be factual and shall include a description of the incident(s) that led to the belief that the Practitioner might be impaired. The individual making the report does not need to have proof of impairment, but must state the facts that led to the suspicions.

d. Matters relating to a Practitioner's health may be addressed in accordance with the Practitioner health or impaired physician policy and may be referred for Investigation in accordance with these Bylaws.

7.2 COLLEGIAL INTERVENTION.

a. These Bylaws require each Member to cooperate with the Hospital, Medical Staff officers, and Medical Staff committees in order to continuously improve individual and collective performance. From time to time, these entities or persons may choose to hold routine discussions with a Member or multiple Members in order to provide education, assistance in providing quality medical care, and encouragement to participate in performance improvement, resource management, or other activities with the Hospital. The routine function of performance improvement, resource management or other programs, and the discussion among Members in that context, does not constitute an Investigation nor entitle members to Hearing rights or right to counsel pursuant to the Fair Hearing Plan or the right to have counsel present.

b. Practitioners are expected to conform their conduct with the expectations set forth in these Bylaws, the Rules and Regulations, and related policies. Conduct which falls below such expectations may be addressed in accordance with the appropriate policy and may be referred for corrective action in accordance with this Section 7.

c. These Bylaws encourage the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address issues pertaining to clinical competence or professional conduct. The goal of these efforts is to arrive at voluntary actions by a Practitioner to resolve an issue that has been raised.

d. Collegial intervention is a part of the Hospital's Professional Review Activities and may include, but is not limited to, the following:

   i. Advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

   ii. Proctoring, monitoring, consultation, and letters of guidance; and

   iii. Sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

e. The relevant Medical Staff leader(s), in conjunction with the Hospital Administrator, may determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the MEC for further action pursuant to this Section 7.

f. The relevant Medical Staff leader(s) will determine whether to document a collegial intervention effort. Any documentation that is prepared will be placed in the Member's confidential file. The Member will have an opportunity to review the documentation and respond to it. The response will be maintained in the Member's file along with the original documentation.

7.3 GROUNDS FOR ACTION

Corrective action is appropriate, whenever, on the basis of information, written, oral or observed, and belief, the Chief of Staff and the Hospital Administrator in conjunction with one of these physicians has cause to question:

a. The clinical competence of any Member;

b. The care or treatment of a patient or patients or management of a case by any Member;

c. The known or suspected violation by any Member of applicable ethical standards, or the Bylaws, policies, rules or regulations of the Hospital or the Board or Medical Staff, including, but not limited to, the Hospital's departmental rules and regulations and quality assessment and risk management programs;

d. The known or suspected exclusion from any Federal Health Care Program; or

e. Behavior or conduct on the part of any Member that is considered lower than the standards of the Hospital or disruptive of the orderly operation of the Hospital or its Medical Staff, including the inability of the appointee to work harmoniously with others.

7.4 INVESTIGATIONS

a. A written request for an investigation of a Member for the issues specified in Section 7.3 shall be addressed to the MEC, making specific reference to the activity or conduct which gave rise to the request. The MEC shall keep the Hospital Administrator fully informed of all action taken in connection therewith.

b. The Medical Executive Committee shall meet as soon as possible after receiving the request for an Investigation. If the request for an Investigation contains sufficient information to warrant an Investigation, the MEC, at its discretion, shall make such a recommendation, and may do so with or without a personal interview with the Practitioner being investigated. If the MEC does not have sufficient information to warrant an Investigation, the MEC may discuss the matter with the Practitioner and the individual making the request and then determine whether an Investigation is warranted. If an Investigation is warranted, the MEC must conduct one.

c. The MEC may investigate on its own, or it may assign the task to an investigative ad hoc committee ("investigating body or committee") consisting of one or more persons. Ad hoc committee members may, but need not be physicians, Members, or persons associated with the Hospital.

d. The investigating body or committee conducting the Investigation shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital and investigating committee that:

i. the clinical expertise needed to conduct the review is not available on the Medical Staff;

ii. the individual under review is likely to raise, or has raised, questions about the objectivity of other Members; or

iii. the Members with the necessary clinical expertise would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

e. The MEC shall inform the Member that an Investigation has begun and shall provide a summary of the specific issues being investigated. Notification may be delayed if, in the MEC's sole judgment, informing the individual immediately would compromise the Investigation or disrupt the operation of the Hospital or the Medical Staff. The investigating body or committee may request the attendance of the Member, upon reasonable notice, for purposes of an interview to provide relevant information to the Investigation. A summary of the meeting shall be made and included in the investigating body or committee's report.

i. No person who performs any part of an Investigation may be in direct economic competition with the Member, unless waived by said Member.

ii. The Chief of Staff and Hospital Administrator shall be fully informed of the progress and intentions of the MEC regarding the Investigation.

iii. Before making a recommendation that would constitute a Professional Review Action or any other disciplinary measure, the MEC must extend a reasonable opportunity to the Member, by notice, to be heard.

f. Neither initial discussions with the Member nor any subsequent interview or meeting held as part of the above Investigation constitutes a Hearing and does not entitle the Member to be represented by legal counsel nor to any Hearing rights under the Fair Hearing Plan.

g. The investigating body or committee shall make a reasonable effort to complete the Investigation and issue its report within forty-five (45) days of the commencement of the Investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating body or committee shall make a reasonable effort to complete the Investigation and issue its report within thirty (30) days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an Investigation completed within such time periods. In

the event the investigating body or committee is unable to complete the Investigation and issue its report within these time frames, it shall inform the Member of the reasons for the delay and the approximate date on which it expects to complete the Investigation.

h. At the conclusion of the Investigation, the investigating body or committee shall prepare a written report with its findings and conclusions for the MEC to consider. The written report may include recommendations for appropriate resolution which may include corrective action. Despite the status of any Investigation, at all times the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the Investigation, or other action.

i. Upon the receipt of the investigating body or committee's report and findings, the MEC must consider the findings and conclusions and prepare a written recommendation with supporting documentation within a reasonable amount of time not to exceed ninety (90) days from submission of the investigating body or committee's report, sending a copy to the Member. The MEC may:

   i. Conclude that the complaint is without merit and that no corrective action is warranted, forwarding the recommendation and documentation to the Board for ratification in accordance with the provisions of this Section;

   ii Recommend no action (i.e., a letter of guidance, counsel, warning, reprimand, non-concurrent mandatory monitoring/consultation, training or education) or action that does not Affect Adversely the Member's appointment or Clinical Privileges and forwarding the recommendation and documentation to the Board for ratification in accordance with the provisions of this Section; or

   iii. Recommend the taking of a Professional Review Action, in which event it must give the Member Notice in accordance with the Fair Hearing Plan.

j. No member of the MEC may take part in the consideration or vote on the recommendation if he or she is in direct economic competition with the Member affected.

k. A recommendation by the MEC of a Professional Review Action that would entitle the Member to request a Hearing pursuant to the Fair Hearing Plan shall be forwarded to the Hospital Administrator, who shall promptly notify the Member of the recommendation. The Hospital Administrator shall hold the recommendation until after the individual has completed or waived a Hearing and Appeal pursuant to the Fair Hearing Plan.

l. If the MEC makes a recommendation that does not entitle the individual to request a Hearing pursuant to the Fair Hearing Plan, it shall take effect immediately and shall remain in effect unless modified by the Board.

m. The MEC may at any time reconsider its recommendation in light of new information and alter its recommendation.

n. When applicable, any recommendations or actions that are the result of an Investigation or Hearing and Appeal shall be monitored by Medical Staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

o. The Board shall review the determination or deferral of the matter by the MEC, and either adopt the determination or action or initiate other corrective action as may be appropriate.

p. In the event the Board considers a modification to the recommendation of the MEC that would entitle the individual to request a Hearing, the Hospital Administrator shall notify the Member. No final action shall occur until the Member has completed or waived a Hearing and Appeal pursuant to the Fair Hearing Plan.

7.5 GROUNDS FOR SUMMARY SUSPENSION

a. The Chief of Staff or the Hospital Administrator shall have the authority to summarily suspend all or any portion of the Clinical Privileges of a Practitioner where the failure to take such action may result in an imminent danger to the health of any individual. Such suspension shall not imply any final finding of responsibility for the situation that caused the suspension. When the action is taken by the Hospital Administrator, consultation will immediately occur with the Chief of Staff.

b. Such summary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the Hospital Administrator, the Chief of Staff of the Medical Staff, and the Chair of the MEC, and shall remain in effect unless or until modified by the MEC or the Board. The summary suspension will be subject to final approval by the Board.

c. The Hospital Administrator shall promptly notify the affected individual of summary suspension by letter to be hand-delivered or sent certified mail, return receipt requested.

7.6 MEDICAL EXECUTIVE COMMITTEE PROCEDURE AND SUMMARY SUSPENSION

a. Any individual who exercises authority under section 7.5 to summarily suspend Clinical Privileges shall immediately report this action to the Medical Executive Committee to take further action on the matter.

b. An investigation of the matter resulting in summary suspension shall be completed within fourteen (14) days of the suspension or reasons for the delay shall be transmitted to the Board so that it may consider whether the suspension should be lifted. At that point, the MEC shall take such further corrective action as is required in the manner specified under this Section 7. The summary suspension shall remain in force after the appropriate committee takes responsibility unless and until modified by that committee or the Board, or until the matter that required the suspension is finally resolved.

7.7 CARE OF SUSPENDED INDIVIDUAL'S PATIENTS

Immediately upon the imposition of a summary suspension or suspension resulting from other actions under this Section, the Chief of Staff of the Medical Staff shall assign to another Practitioner with appropriate Clinical Privileges responsibility for the care of the suspended Practitioner's patients still in the Hospital at the time of such suspension until such time as they are discharged. The wishes of the patients shall be considered in the selection of the assigned Practitioner.

7.8 AUTOMATIC SUSPENSIONS AND TERMINATIONS

a. Events Resulting in Automatic Suspension or Termination. The following events result, without further notice or action, in an automatic termination or suspension of a Member's appointment and Clinical Privileges:

i. Actions Affecting State License to Practice or DEA Registration. If a Practitioner's actions result in his/her state license to practice or DEA registration being revoked, suspended, censured, restricted/limited for disciplinary reasons, not renewed by the relevant agency, or voluntarily relinquished by the Practitioner, then Medical Staff appointment and Clinical Privileges are automatically revoked, suspended or limited to at least the same extent as the state licensure to practice or DEA registration, subject to reapplication by the Practitioner when/if his license is reinstated, or limitations are removed, whatever is the case. However, an indefinite suspension of licensure or registration shall be treated as a revocation of appointment and Privileges, as applicable.

ii. Exclusion from a Federal Health Care Program. A Member must, immediately upon notice of any proposed or actual exclusion from any Federal Health Care Program, disclose to the Hospital Administrator, or his or her designee, by telephone call and in

writing, any notice to the Member or his representative of proposed or actual exclusion of the Member from any Federal Health Care Program. The Member may make a request in writing for a meeting with the Hospital Administrator and the Chief of Staff, or their designees, to contest the fact of the exclusion and present relevant information. If requested, such a meeting shall be held as soon as possible but in no event later than five (5) business days from the date of the written request. The Hospital Administrator and the Chief of Staff or their designees shall determine within ten (10) business days following the meeting, and after such follow-up investigations as they deem appropriate, whether the exclusion had in fact occurred, and whether the Member's appointment and Clinical Privileges shall be immediately terminated. The determination of the Hospital Administrator or the Chief of Staff or their designees regarding the matter shall be final, and the Member shall have no Hearing rights pursuant to the Fair Hearing Plan. The Member shall be given notice of the termination in the most expeditious manner possible, and shall also promptly receive notice of the termination.

iii. Sanctions by a Government Program. Any Practitioner will be automatically suspended from the Medical Staff if they are sanctioned by a Federal Health Care Program.

iv. Failure to Comply With Meeting Requirements. For Members of Medical Staff categories requiring compliance with meeting attendance requirements, failure to comply with such requirements will result in an admonishing letter and probationary Active Staff status for six (6) months. If during that six (6) month time, meeting requirements are not complied with, then the Member loses the right to vote or hold office, regardless of the level of his/her clinical activity at the Hospital. Additionally, failure without good cause of a Practitioner, after notice, to appear at a meeting of the MEC, of an investigating body or committee, or of the Board called to discuss the proposed taking of a Professional Review Action or any other disciplinary action shall result in the automatic suspension of the Member's appointment and Privileges.

v. Lapse or Failure to Carry Liability Insurance. If the Board and MEC have established a minimum level or requirement for liability insurance coverage for Practitioners with Clinical Privileges, and if a Practitioner's liability insurance lapses or is cancelled without renewal, then the Practitioner's rights and Clinical Privileges are automatically suspended until the effective date of his or her new liability insurance coverage, unless otherwise determined by the Board, considering the input of the MEC.

vi. Criminal Activity. Actual or pending criminal convictions, meaning

conviction of, pleas of guilty, or no contest pertaining to any felony charges; or actual or pending conviction of, plea of guilty, or no contest to misdemeanor charges in which the underlying allegations involve the practice of a health care profession, Federal Health Care Program fraud or abuse, third party reimbursement, the use of alcohol or controlled substances, crimes of violence or abuse, or crimes of moral turpitude.

b. Practitioner's Appointment and Clinical Privileges will be automatically relinquished upon notice to the Practitioner by the MEC, without entitlement to Hearing rights pursuant to the Fair Hearing Plan, if the individual fails to satisfy any of the other threshold eligibility criteria set forth in these Bylaws.

c. Automatic relinquishment of Appointment and Clinical Privileges will take effect immediately upon notice to the Hospital and will continue until the matter is resolved, if applicable. If an individual engages in any patient contact at the Hospital after the occurrence of an event that results in automatic relinquishment of appointment and Privileges, without notifying the Hospital of that event, then the relinquishment will be deemed permanent.

d. Failure of the Practitioner to resolve the underlying matter leading to an individual's Clinical Privileges being automatically relinquished in accordance with this Section (other than exclusion from a Federal Health Care Program), within seven (7) days of the notice of relinquishment will result in automatic resignation from the Medical Staff. The Practitioner's Clinical Privileges and appointment remain suspended during such period until the MEC acts.

e. With the exception of exclusion from a Federal Health Care Program, the MEC must promptly meet and consider any evidence the Practitioner submits.

   i. If the MEC determines that grounds for automatic termination did not exist, it must immediately restore the Practitioner to full appointment or Clinical Privileges, as appropriate.

   ii. If the MEC determines that grounds for termination were valid, it must promptly give notice to the Member that the termination remains in effect and that he/she may reapply for such appointment or Privileges for which he/she may qualify at such time as the grounds for termination are resolved.

   iii.. Automatic terminations do not entitle a Practitioner to any Hearing or Appeal rights pursuant to the Fair Hearing Plan, nor right to legal counsel with the MEC.

f. Requests for reinstatement will be reviewed by the Hospital Administrator and Chief of Staff. If a favorable recommendation is made for reinstatement, the Member may immediately resume exercising Clinical Privileges at the Hospital. This determination will then be forwarded to the MEC and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the MEC and the Board for review and recommendation.

7.9 TEMPORARY ADMINISTRATIVE SUSPENSIONS

a. A Member's Clinical Privileges (except with respect to patients already admitted to the Hospital) may be suspended in accordance with the Rules and Regulations for failure to properly complete medical records or failure to meet financial responsibilities, if levied. Such suspension is effective upon receipt of a notice of deficiency.

   i. Failure to Complete Medical Records. All portions of each patient's medical record, including discharge summaries, shall be completed within time frames specified in the Rules and Regulations after the patient's discharge. Failure to do so (unless there are acceptable extenuating circumstances as approved by the MEC) automatically results in the record being defined as delinquent, notification to the Practitioner of the delinquency, and temporary suspension of the Member's Clinical Privileges until such time as the delinquent record is completed.

   ii. Failure to Meet Financial Responsibilities. If, at any time, a Practitioner fails to meet financial responsibility requirements, the Practitioner's Clinical Privileges shall be voluntarily relinquished or restricted as applicable as of that date and until such financial responsibility requirements are met.

b. Temporary administrative suspensions remain in effect for as long as the deficiency remains uncured.

c. A Member may appeal a temporary administrative suspension to the MEC. The MEC's determination is final and is not subject to further review.

d. The Chief of Staff or the MEC may allow exceptions and permit exercise of Clinical Privileges upon a showing by the Member of special circumstances.

e. If a temporary administrative suspension lasts longer than thirty (30) days and the MEC has determined that the deficiency was based on professional conduct or competence and had the potential to adversely

affect patient care, the Practitioner shall be entitled to the Hearing rights pursuant to the Fair Hearing Plan and the suspension may be reportable to the Data Bank and/or the state licensure board.

f. Temporary administrative sanctions imposed hereunder do not limit the MEC or the Board from taking other corrective action when a Member fails to properly complete medical records or meet financial responsibilities.

7.10 PROCEDURE FOR LEAVE OF ABSENCE

a. Any Member who will be absent for a period of longer than thirty (30) days must apply for a leave of absence.

b. Members may be granted leaves of absence by the Board for a definitely stated period of time not to exceed one (1) year. Absence for longer than one (1) year shall constitute voluntary resignation of Medical Staff appointment and Clinical Privileges unless an exception is made by the Board. If the appointment or reappointment period lapses during the leave of absence, the Practitioner shall reapply for appointment and Clinical Privileges as outlined in these Bylaws.

c. Requests for leaves of absence shall be made to the Hospital Administrator, and shall state the beginning and ending dates of the requested leave. The Hospital Administrator shall transmit the request together with a recommendation to the Board. No decision on a leave of absence will be subject to a review or give rise to a right of any Hearing pursuant to the Fair Hearing Plan.

d. At the conclusion of the leave of absence, the Member may be reinstated, upon filing a written statement with the Hospital Administrator summarizing professional activities undertaken during the leave of absence. The Member shall also provide such other information as may be requested by the Hospital at that time. A Member returning from a leave of absence for health reasons must provide a report from his/her physician indicating that the Member is capable of resuming the exercise of Clinical Privileges safely and completely. A recommendation will be transmitted to the Board. Failure to make a timely and appropriate request for reinstatement will result in termination of the Member's membership and Privileges without right of review.

e. In acting upon the request for reinstatement, the Board may approve reinstatement either to the same or a different staff category, and may limit or modify the Clinical Privileges to be extended to the individual upon reinstatement.

7.11 RESIGNATION

A Member may resign his or her appointment or Privileges, including specific individual

Privileges, by submitting a written resignation to the Board. The resignation is effective when acted upon by the Board. The Board may condition acceptance of the resignation upon the Member's orderly completion of medical records or other pending responsibilities of the Member or the fulfillment of negotiated contractual terms.

ARTICLE VIII

IMMUNITY, CONFIDENTIALITY, AND RELEASE

8.1 AGREEMENT TO BE BOUND

By submitting an application for Medical Staff appointment or a request for Clinical Privileges, regardless of whether the Applicant is awarded such appointment or Clinical Privileges, each Practitioner agrees to be bound by the specific provisions of this Article VIII.

8.2 INFORMATION COLLECTION AND HANDLING

a. "Hospital Representatives" (defined in this Section to mean the Board, each Board member, each Board committee, the Hospital Administrator, the Chief of Staff, the Medical Staff, each Member, officer and committee thereof, each attorney and each other individual who is authorized to gather, analyze, use or disseminate information concerning Practitioners) are specifically authorized to solicit, receive and act upon information relating to a Practitioner's qualifications.

b. Third parties are specifically authorized to release information about a Practitioner's qualifications to Hospital Representatives.

c. Hospital Representatives are specifically authorized to release information about a Practitioner's qualifications to other hospitals, health care entities, authorized health care licensing, data collection or reporting agencies, to the extent consented to in this Article VIII or to the extent required or permitted by law.

8.3 CONFIDENTIALITY OF PROFESSIONAL REVIEW ACTIVITIES

a. Members who serve on Professional Review Bodies are entitled to preserve the confidentiality of their Professional Review Activities from disclosure to reviewed Practitioners and to others in order to foster candid and complete assessments of professional qualifications. Practitioners whose qualifications are reviewed are likewise entitled to the confidentiality and disclosure of information about them to others only in the manner permitted by law and by these Bylaws.

b. Practitioners are forbidden to disclose Peer Review Matter (as defined below) to any other person, except as expressly provided in this Section.

c. "Peer Review Matter" includes:

i. Information, data, reports or records supplied by any person to a Hospital Representative in furtherance of a Professional Review Activity;

ii. Information, data, reports or records created by a Professional Review Body or by any of its members, employees, assistants or persons under contract in the course of a Professional Review Activity;

iii. Conversations, discussions, deliberations, testimony or other oral communications relating to Professional Review Activities; and

iv. Reports that a Professional Review Body may take to the Data Bank.

d. Peer Review Matter may be disclosed to others only:

i. As may be permitted or required by applicable state and federal law or by a court of competent jurisdiction; or

ii. As may be specifically authorized in a written consent by both the Practitioner and the unanimous approval of the Professional Review Body.

8.4 IMMUNITY AND RELEASE

a. Each of the following persons acting in good faith is immune from civil liability for damages or other relief, and each Practitioner specifically releases from all civil liability:

i. Each person who provides information to a Hospital Representative in furtherance of a Professional Review Activity;

ii. Each Hospital Representative who participates in a Professional Review Activity, including but not limited to, each Professional Review Body; each person acting as a member or staff to the Professional Review Body; each person under contract or other formal arrangement with either a Hospital Representative or the Professional Review Body; and each person who participates with or assists the Professional Review Body; and

iii. Each third person to whom a Hospital Representative releases information.

b. In the event that a Hospital Representative takes or investigates the taking of a Professional Review Action, each Practitioner agrees to

exhaust all steps set forth in these Bylaws, including administrative review and the exercise of his rights, if any, pursuant to the Fair Hearing Plan as his or her exclusive remedy respecting that Professional Review Action.

8.5 IMMUNITIES CUMULATIVE

The immunities provided in this Section are cumulative and do not limit or restrict immunities that are otherwise available under law.

ARTICLE IX

HEARING AND APPELLATE REVIEW PROCEDURE

9.1 EXHAUSTION OF REMEDIES

If Adverse Action is taken or recommended in regard to a Practitioner, the Practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

9.2 GROUNDS FOR HEARING

Except as otherwise specified in these Bylaws, the following actions or recommended actions shall be deemed adverse actions and constitute grounds for a Hearing:

a. Denial of Medical Staff membership;

b. Denial of requested advancement in Medical Staff membership status or category;

c. Denial of Medical Staff reappointment;

d. Demotion to lower Medical Staff category or membership status if such denial is based on professional competence or conduct;

e. Summary suspension of Medical Staff membership for a period of more than fourteen (14) days;

f. Revocation of Medical Staff membership;

g. Denial of requested Clinical Privileges (excluding temporary privileges) if such denial is based on professional competence or conduct;

h. Involuntary reduction of current Clinical Privileges (excluding temporary privileges);

i. Summary suspension of Clinical Privileges (excluding temporary privileges

for a period of more than fourteen (14) days); or

j. Termination of all Clinical Privileges (excluding temporary privileges) if such denial is based on professional competence or conduct.

9.3 NOTICE AND REQUEST FOR A HEARING.

a. Notice of Adverse Action or Recommendation.

When a recommendation Adversely Affects a Member, he/she shall be given notice promptly, and in no event later than three (3) days, by the Hospital Administrator, in writing, return receipt requested. The notice shall include a statement of the specific Adverse Action taken or recommended and the reason(s) therefor. The notice also shall include a summary of the individual's Hearing rights pursuant to the Fair Hearing Plan, including that the Member must request a Hearing within thirty (30) days of receipt of the notice.

b. Request for Hearing.

The Applicant or Member has thirty (30) days following receipt of the notice of a recommendation having an Adverse Affect to request a Hearing. The request must be by written Notice, mailed return receipt requested, to the Hospital Administrator. The request for a Hearing must indicate in what respect, from the affected Member's point of view, the action or recommendation is in error and on what points the Member wishes to Appeal. The request must be postmarked on or before the 30th day following the individual's receipt of the Notice. If a Hearing is not requested within thirty (30) days, the applicant or Member has waived his or her right to a Hearing and has accepted the recommendation, which will become effective immediately.

c. One Hearing.

No Applicant or Member shall be entitled to more than one (1) Hearing upon the same Adverse Action.

9.4 THE HEARING: PROCEDURAL DETAILS

a. Arrangements for the Hearing.

Upon receipt of a request for a Hearing, the Hospital Administrator will schedule the Hearing and mail a Notice of the Hearing, return receipt requested, to the person who requested the Hearing, of its time, place and date, which shall not be less than thirty (30) days after the date of the Notice of the Hearing, but as soon thereafter as possible, considering the schedules and availability of all concerned. The Notice of the Hearing shall include:

i. A statement of the reasons for the action taken or recommended, as well as those acts, omissions, charges, or violations which serve

as the grounds for the Adverse Action together with the identity of patient records and any other relevant information supporting the Adverse Action;

ii. A statement that if he/she does not personally appear at the Hearing, she/she forfeits all rights to a Hearing and Appeal; and

iii. A list of witnesses (if any) expected to testify at the Hearing on behalf of the professional body making the Adverse Action.

iv. The identity of the Hearing Panel and the Presiding Officer.

The statement and attached information may be amended or added to at any time, even during the Hearing, if additional material is relevant to the Hearing, and provided that the person requesting the Hearing and his or her counsel have sufficient time to study the additional information and offer rebuttal.

b. The Presiding Officer.

The Hospital Administrator may appoint a person to preside at the Hearing (the "Presiding Officer"). The Presiding Officer may be legal counsel to the Hospital, but in any event must not act as a prosecuting officer or as an advocate for the Board or Medical Staff. The Presiding Officer may participate in private deliberations of the Hearing Panel, and may provide legal advice to it, but is not entitled to vote on its recommendations unless the Presiding Officer is also the chairperson of the Hearing Panel, as described below. The Presiding Officer may, following the Hearing, continue to advise the Board and Medical Staff on the matter. The Presiding Officer may not be in direct economic competition with the person requesting the Hearing.

If no Presiding Officer is appointed, the designated chairperson of the Hearing Panel will be the Presiding Officer.

The Presiding Officer may, in his/her sole discretion, hold a pre-Hearing conference to simplify or clarify the issues to be heard, resolve disputes, facilitate settlement, specify the timing and order of witnesses or to address any other matter that may facilitate the just, speedy and inexpensive disposition of the Hearing.

The Presiding Officer ensures that all participants have a reasonable opportunity to be heard, maintains order, determines the order of procedure of the Hearing in accordance with these Bylaws, may set reasonable time limits for the Hearing, and makes rulings on questions pertaining to matters of procedure and admissibility of evidence. It is understood that the Presiding Officer at all times is concerned that all relevant information be made available to the Hearing Panel for its deliberations and recommendations to the Board. The Presiding Officer may make official mention of matters relating to the issues under consideration. All participants in the Hearing are informed of such matters, and they are noted

in the record of the Hearing. Either party may request that a matter be officially mentioned or may provide a counter argument to be included in the Hearing record.

The Presiding Officer shall have the authority to:

i. advise the Hearing Panel on the standard of review at the Hearing and on the procedures and standards applicable to the Hearing process and the matter under review;

ii. schedule and conduct pre-Hearing proceedings;

iii. determine the order of or procedure for presenting evidence and statements during the Hearing and allot time to the parties;

iv. make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence;

v. require the exchange of information, case outlines, witness lists, and exhibits between the parties, and the common marking of exhibits;

vi. require the witnesses be sworn and that testimony be taken under oath;

vii. request the stipulation of uncontested facts; and

viii. if the Presiding Officer determines that a party to a Hearing is not proceeding in an efficient and expeditious manner, take such discretionary action as he or she deems necessary.

c. The Hearing Panel.

The Hospital Administrator, after considering the recommendations of the Chief of Staff and the Board Chairperson, appoints a Hearing Panel of not less than three (3) Members, at least two (2) of whom must be physicians. Knowledge of the matter being considered does not preclude appointment to the Hearing Panel, as long as they indicate such prior knowledge will not interfere with rendering a decision on the basis of evidence present at the Hearing, but Members who have actively participated in the consideration of the matter at any previous level are not eligible for appointment to the Hearing Panel. No member of the Hearing Panel may be in direct economic competition with the person requesting the Hearing or have other business, family or professional relationship likely to undermine their ability to render a decision on the basis of evidence presented at the Hearing. The Hospital Administrator will also designate a Hearing Panel chairperson. A member of the Hearing Panel may also not be expected to be called as a key witness at the Hearing.

d. Establishing Qualifications.

The Hospital Administrator shall furnish the members of the Hearing Panel and the Presiding Officer with a questionnaire confirming the members of the Hearing Panel or the Presiding Officer: (i) are not disqualified due to any of the factors listed above; (ii) are not aware of any business, family or practice relationship that would undermine their ability to serve; and (iii) will be able to decide the matter based on the evidence produced at the Hearing. The completed and signed questionnaires shall become a part of the Hearing record. The Hospital Administrator may remove a member of the Hearing Panel or the Presiding Officer based on their responses to the questionnaires.

e. Hearing Officer.

i. In very limited circumstances where a Hearing Panel of impartial peers is unavailable and/or for matters unrelated to clinical competence, after consulting with the MEC, the Hospital Administrator or his or her designee, may appoint an individual, with background, knowledge, and experience appropriate to the subject matter of the Hearing, to serve as a Hearing Officer, provided that such individual is not in direct economic competition with the individual requesting the Hearing, is not professionally associated with, related to, or involved in a referral relationship with, the individual requesting the Hearing, and has not demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

ii. If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article IX to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer to the Hearing Officer.

f. Representation.

The individual requesting the Hearing may be represented by an attorney, or other person of the individual's choice, who shall enter his appearance in writing with the Hospital Administrator at least ten (10) days prior to the date of the Hearing. The Hospital may be represented by counsel in the Hearing, and counsel for the Hospital shall enter his/her appearance in the same manner.

g. Specified Rights.

The person requesting the Hearing and the Hospital may:

i. Choose to have a record made of the proceedings, copies of which may be obtained by the Member upon payment of any reasonable charges associated with the preparation thereof;

ii. Call and examine witnesses;

iii. Introduce exhibits and evidence determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law;

iv. Cross-examine witnesses, on matters determined by the Hearing Panel or Presiding Officer, as applicable, to be relevant to the issues;

v. Provide rebuttals at the Hearing for any evidence presented; and

vi. Submit a written statement at the close of the Hearing.

Even if the person requesting the Hearing decides not to testify on his or her own behalf, he or she may still be called as a witness and examined as if under cross-examination.

h. Burden of Proof.

It is incumbent on the MEC or the Board, whichever made the Adverse Action, to come forward with evidence in support of its decision or recommendation. With that exception, the burden of proof is on the person who requested the Hearing. The MEC or the Board, whichever body rendered the decision from which the Member has requested the Hearing, shall name a spokesman to represent it at the Hearing.

Unless the Hearing Panel finds that the individual who requested the Hearing has proven that the Adverse Action was unreasonable, not supported by substantial evidence brought before the Hearing Panel, or otherwise unfounded, the Hearing Panel shall recommend in favor of the MEC or the Board (whichever group's action occasioned the Hearing).

i. Pre-Hearing Procedures.

i. Outlines of Case. At any time during the proceedings, the Presiding Officer may require the affected Practitioner and the MEC to each submit a case outline setting forth, so far as is then reasonably known, issues which each party proposes to raise at the Hearing; witnesses whom each party proposes to call at the Hearing and the subject or subjects on which each witness will testify; a description of written or documentary evidence which each party anticipates introducing as evidence at the Hearing; a short summary of what the party expects to demonstrate at the Hearing in support of its position; and/or the specific result requested from the Hearing Panel.

ii. Pre-Hearing Conference. Prior to the scheduled Hearing, the Presiding Officer shall conduct a pre-Hearing conference in person or by conference call to discuss possible stipulations of fact,

amendments to the grounds for action or the issues in the dispute, and changes in the witness or evidence lists, and to narrow the issues for Hearing. The Presiding Officer shall have authority to limit the issues, arguments, witness, and exhibits at the Hearing to conform to the orders and stipulations at the pre-Hearing conference. Failure of either party to appear and participate in the preliminary meeting shall be deemed to be acceptance of all agreements and decisions made at or as a result of the preliminary meeting.

j. Provision of Relevant Information.

i. Prior to receiving any confidential documents, the individual requesting the Hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the Hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate Agreements ("BAAs") in connection with any Protected Health Information (as defined at 45 C.F.R. § 160.103) contained in any documents provided.

ii. Upon receipt of the BAA and representation, the individual requesting the Hearing will be provided with a copy of the following:

A. copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

B. reports of experts relied upon by the MEC; and

C. copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted).

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

iii. The individual will have no right to discovery beyond the above information. No information will be provided regarding other Practitioners on the Medical Staff.

iv. Prior to the pre-Hearing conference, on dates set by the Presiding Officer or as agreed upon by both sides, each party will provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, will be submitted in writing in advance of the pre-Hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

v. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for Appointment or the relevant Clinical Privileges will be excluded.

vi. Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees whose names appear on the MEC's witness list or in documents provided pursuant to this Section concerning the subject matter of the Hearing, until the Hospital has been notified and has contacted the employees about their willingness to be interviewed. The Hospital will advise the individual once it has contacted such employees and confirmed their willingness to meet with the individual. Any employee may agree or decline to be interviewed by or on behalf of the individual who requested a Hearing.

k. Admissibility of Evidence.

No written evidence, testimony, or documentation shall be considered by the Hearing Panel, which has not been made available to both parties for rebuttal, or received as evidence at a meeting at which both sides have had the opportunity to be present. Any evidence shall be admitted by the Presiding Officer at the Hearing which is relevant to the issues before the Hearing Panel and is the sort of evidence upon which reasonable persons are accustomed to rely in the conduct of serious affairs without regard to the admissibility of such evidence in a court of law. The Hearing Panel may, but is not required to, adhere to state or federal rules governing the presentation of evidence or examination of witnesses at trial or in a court of law. The Hearing Panel may itself question witnesses, call additional witnesses, and request documentation of charges or claims made.

l. List of Witnesses.

Each party must provide the other in writing, at least ten (10) days in advance of the Hearing, a written list of names and addresses of witnesses to be called. The witness list of either party may be amended at any time during the course of the Hearing for good cause shown. Testimony of character witnesses and patients who can testify to their confidence in the affected Practitioner will not be considered relevant to the proceedings.

m. Failure to Appear.

If the individual requesting the Hearing, without good cause, fails to appear at the time the Hearing is scheduled, such failure constitutes voluntary acceptance of the Adverse Action, which then will become effective immediately. Failure without good cause of the Board or MEC or its designee to appear and proceed at such a Hearing will be deemed to constitute a withdrawal of the recommendation or action involved.

n. Nonpublic Hearing.

Proceedings will be conducted in private before the parties and their representatives, the Hearing Panel members, and the court reporter.

o. Postponements and Extensions.

Postponements and extensions of the Hearing may be requested by either party, but will be permitted by the Hearing Panel only for good cause.

p Hearing Record.

A record of the Hearing will be maintained by a court reporter retained by the Hospital. Copies of the record may be obtained by the applicant or Member upon payment of any reasonable charges imposed by the court reporter associated with the preparation thereof.

q. Attendance by Panel Members.

No quorum is required in order for the Hearing Panel to proceed, but the decision of the Hearing Panel must be by majority of all those appointed to the Hearing Panel.

r. Recess.

The Hearing Panel may recess the Hearing and reconvene the same for the conveniences of the participants or for the purpose of obtaining new or additional evidence or consultation.

s. Conclusion of the Hearing Procedure.

After both parties have concluded their presentation of oral and written evidence, the Hearing is closed. At such point, the individual may submit a written statement for the Hearing Panel's consideration.

t. Recommendation.

Within twenty (20) days after conclusion of the Hearing, and following any private deliberations that may be necessary, a recommendation and a report containing the reasons for the recommendation shall be prepared by the Hearing Panel and delivered to the Hospital Administrator. At any time prior to rendering its decision, the Hearing Panel may, in its discretion, upon fair notice to each party, reconvene the Hearing and receive additional evidence or argument. The recommendation must be based on the evidence produced at the Hearing. The supporting evidence may be stated as "Factual Findings" of the Hearing Panel and contain a proposed report to the Data Bank.

u. Further Distribution of Hearing Panel Report and Recommendation.

The Hospital Administrator shall send a copy of the Hearing Panel's report and recommendation, return receipt requested, to the individual who requested the Hearing, and to the body whose Adverse Action initiated the Hearing. That body then decides whether to modify its original recommendation or action, considering the report and recommendation of the Hearing Panel.

9.5 NOTICE AND REQUEST FOR AN APPEAL

Within thirty (30) days of receiving Notice of the Hearing Panel's decision, the individual or the Hospital representative may request an appellate review of the decision. This request must be by written notice, mailed return receipt requested to the President and to the other party. The request must be postmarked on or before the thirtieth (30th) day following receipt of the Notice of the Hearing Panel's decision. The request must include a brief statement of the reasons for the Appeal. The sole grounds for reversal of a decision or Appeal are the following types of errors:

a. Substantial failure on the part of the Medical Staff or the Board to comply with these Bylaws in the conduct of proceedings affecting the individual;

b. That the recommendation or action was made or taken arbitrarily, capriciously, or with prejudice;

c. That a recommendation or action of the MEC or Hearing Panel or the decision of the Board was not supported by substantial evidence.

If an Appeal is not requested within the thirty (30) day time period, the individual and the Hospital have accepted the decision and the action taken is immediately effective.

9.6 APPEAL: PROCEDURAL DETAILS

a. Arrangements for Appellate Review.

When an Appeal is requested, the Board Chairperson, or his or her designee, within ten (10) days of receiving such request, shall schedule and arrange for an appellate review. Notice of the time, date and place will be given to the appealing party. The date for appellate review must not be less than thirty (30) days after the request is received. When the individual appealing is under suspension, then the appellate review shall be held as soon as arrangements can reasonably be made, but not more than fourteen (14) days from receiving the Appeal request. The stated times within which appellate review must be accomplished may be extended by the Board for good cause shown.

b. Appellate Review Panel and Procedures.

The Board Chairperson shall appoint an Appellate Review Panel of not less than three (3) persons, which must include at least one (1) physician, which may include members of the Board, but which may not include persons in direct

economic competition with the individual appealing, playing any part in the presentation of the Appeal or having participated in any earlier Investigation or decision of the matter. The Appellate Review Panel considers Hearing Panel's record.

The Appellate Review Panel may accept additional oral or written evidence only if the party seeking to admit additional evidence can demonstrate on the basis of the record that he or she was deprived of the opportunity to admit it at the Hearing which is under Appeal.

Each of the two parties in the matter have the right to present a written statement in support of their position on the Appeal and, in its sole discretion, the Appellate Review Panel may allow a representative of each party to appear personally and make oral arguments.

The Appellate Review Panel's function is not to function as a Hearing Panel and rehear evidentiary presentations. Rather, the Appellate Review Panel's function is to review the Hearing Panel's record, to accept additional evidence as provided above, and to determine only whether:

a. there was substantial failure on the part of the Medical Staff or the Board to comply with these Bylaws in the conduct of proceedings affecting the individual;

b. the Adverse Action was made or taken arbitrarily, capriciously or with prejudice; or

c. the recommendation or action of the MEC or the Hearing Panel, or the decision of the Board was not supported by substantial evidence.

Unless it remands the matter back to the Hearing Panel for further consideration, the Appellate Review Panel must make a recommendation to the Board within fifteen (15) days after conclusion of the appellate review and based on its determination with respect to the foregoing issue, the Appellate Review Panel will recommend, in writing, final action to the Board. If the Appellate Review Panel determines there was no error of the type specified above, then the Appellate Review Panel will recommend that the decision, action or recommendation under Appeal be made final.

The Board may accept, modify, or reverse the recommendation of the Appellate Review Panel, only for good cause. But the Board shall not function as another appellate forum. When further review is necessary, a report back to the Board shall be accomplished within thirty (30) days, unless a reasonable extension is granted by the Board. The final Board decision is arrived at within thirty (30) days after the conclusion of the appellate review, and is provided in writing delivered in person or by certified mail to the affected individual and to the MEC, including a statement of the basis for the decision.

The decision of the Board following the Appeal is effective immediately, is final, and is not subject to further Hearing or Appeal rights pursuant to the Fair Hearing Plan.

c. Only One Appeal.

An individual is entitled to only one appellate review of any single Adverse Action.

d. Reapplication Following an Adverse Action on Appellate Review.

If the final decision of the Board following an Appeal Adversely Affects the individual, the individual may re-apply for Appointment to the Medical Staff, or for the denied Clinical Privileges, whatever is applicable, one (1) year or later from the Board's final decision or Appeal, unless the Board provides otherwise in its final written decision.

e. Reporting Requirements.

The Hospital must report to the Data Bank and/or the state board of licensure, as required:

i. Each final Professional Review Action that Adversely Affects a Member's Clinical Privileges;

ii. Suspension or voluntary withdrawal of Appointment or Clinical Privileges for a period in excess of thirty (30) days either:

A. While the Practitioner is under Investigation; or

B. In return for not conducting an Investigation.

9.7 EXCEPTIONS TO HEARING RIGHTS

a. Medico-Administrative Officers and Contract Practitioners

Practitioners who are subject to a contract with the Hospital in a medico-administrative capacity or pursuant to a contract to deliver medical services to patients of the Hospital are not entitled to the procedural rights if their Medical Staff membership, status, or privileges are restricted, terminated, or modified pursuant to the terms of the contract with the Hospital. If, however, a contract practitioner's Medical Staff status, membership, or privileges are modified, restricted, or terminated because of issues relating to professional character, competence, or ethics, the contract practitioner shall be entitled to the procedural rights of this Article.

ARTICLE X

OFFICERS

10.1 OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be:

Chief of Staff
Chief of Staff Elect
Secretary/Treasurer

10.2 QUALIFICATIONS OF OFFICERS

Officers shall be appointed from the active Medical Staff who are in good standing and must remain in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

10.3 ELECTION OF OFFICERS

a. Officers shall be elected at the annual meeting of the Medical Staff or at a special meeting of the Medical Staff called for the purpose of electing the officers of the Medical Staff. Officers shall be elected by a simple majority of staff members eligible to vote. Only appointees of the active Medical Staff shall be eligible to vote.

b. Staff members eligible to vote must attend the annual or special meeting and vote in person or submit written proxies in advance.

c. A slate of officer candidates shall be selected by the Medical Executive Committee.

d. Nominations for officer candidates shall also be allowed from the floor.

e. The Board must ratify the Medical Staff member elected Chief of Staff of the Medical Staff. Other elected officers are presented to the Board for information purposes.

10.4 TERM OF OFFICE

a. All Medical Staff Officers shall serve a two-year term from the first day of the calendar year, after they are elected. Officers may succeed themselves only once in the same office.

b. The recall of an officer of the Medical Staff can be accomplished at any regular or called general staff meeting, provided there is a quorum and that a majority of the voting members present vote for the recall.

10.5 VACANCIES IN OFFICE

Vacancies in office during the Medical Staff year, except for the Chief of Staff shall be filled by the Medical Executive Committee of the Medical Staff. If there is a vacancy in the office of the Chief of Staff, the Chief of Staff Elect shall serve out the remaining term.

10.6 DUTIES OF OFFICERS

a. Chief of Staff

The Chief of Staff shall serve as the administrative officer of the Medical Staff to:

i. act in coordination and cooperation with the Hospital Administrator in all matters of mutual concern within the Hospital;

ii. call, preside at, and be responsible for the agenda of all general staff meetings of the Medical Staff;

iii. serve on the Medical Executive Committee and serve as its Chairperson;

iv. serve as ex-officio member of all other Medical Staff committees;

v. be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations;

vi. appoint committee members to all standing, special, and multidisciplinary committees except as otherwise provided;

vii. present the views, policies, and needs of the Medical Staff to the Board and Hospital Administrator;

viii. interpret the policies of the Board to the Medical Staff, and report to the Board on performance and maintenance of quality patient care;

ix. be responsible for the educational activities of the Medical Staff; and,

x. be responsible for the organization and conduct of the Medical Staff.

b. Chief of Staff Elect

In the absence of the Chief of Staff, the Chief of Staff Elect assumes the duties and authority of the Chief of Staff. In addition, the Chief of Staff

Elect shall:

i. serve on the Medical Executive Committee;

ii. automatically succeed the Chief of Staff when the latter fails to serve for any reason;

iii. perform such reasonable duties as may be assigned to him by the Chief of Staff and/or these Bylaws; and

iv. succeed the Chief of Staff at the end of the Chief of Staff's term.

c. Secretary/Treasurer

The Secretary/Treasurer shall:

i. serve on the Medical Executive Committee;

ii. provide for accurate and complete minutes of all Medical Staff meetings;

iii. call Medical Staff meetings on order of the Chief of Staff;

iv. provide for a record of attendance at meetings;

v. attend to all correspondence on behalf of the staff;

vi. make minutes and correspondence available to the Board;

vii. account for staff funds; and

viii. pay bills as authorized.

ARTICLE XI

COMMITTEES AND FUNCTIONS

11.1 TYPES OF COMMITTEES

There shall be a Medical Executive Committee, a Pharmacy & Therapeutics Committee, a Quality Management Committee, and such other permanent and temporary committees of the Staff as may from time to time be necessary.

Permanent Medical Staff committees may be established by the Medical Executive Committee upon approval of the Board, but temporary (ad hoc) committees may be established solely by the Medical Executive Committee.

11.2 MEDICAL EXECUTIVE COMMITTEE

The Medical Executive Committee shall be comprised of members of the active medical staff who are licensed as either medical physicians or osteopathic physicians.

a. Composition

The Medical Executive Committee shall consist of:

Voting members

- Chief of Staff of Staff
- Chief of Staff Elect of Staff
- Secretary/Treasurer
- Two (2) members-at-large elected by the Medical Staff
- Immediate Past Chief of Staff

Ex-Officio Members (without vote)

- Hospital Administrator or designee
- Chief Medical Officer
- Director of Nursing

b. Duties

The duties of the Medical Executive Committee shall be:

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

(2) to approve and ensure the implementation of all clinical policies and procedures;

(3) to coordinate the activities of and policies adopted by the Medical Staff and committees;

(4) to receive and act upon reports and recommendations from the committees and officers of the Medical Staff concerning accountability (quality improvement) activities and other responsibilities;

(5) to recommend to the Board all matters relating to appointments, reappointments, Medical Staff category and clinical privileges;

(6) to pursue corrective actions to necessary conclusions;

(7) to make recommendations on medical-administrative and Hospital

management affairs, including patient care needs such as space, staff, and equipment;

(8) to obtain Medical Staff cooperation with initiatives to obtain or retain accreditation status for the Hospital;

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

(10) to annually nominate members of the active Medical Staff, in good standing, to the slate of candidates for election of officers.

(1) to perform the credentialing activities of the Medical Staff in order to ensure that patients receive care, treatment, and services from qualified providers.

Duties in this role shall be:

(i) to review new and renewal applications for appointment to the medical staff at the beginning of each Medical Executive Committee meeting;

(ii) to insist on validation of information provided in support of applications, including all reports from the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank;

(ii) to verify with the General Services Administration (GSA) and Health and Human Services Office of Inspector General (HHS/OIG) whether the applicant has been excluded from any Federal or State healthcare program;

(iii) to conduct a thorough, objective, and fair review of applications for Medical Staff membership and clinical privileges, both initial appointment and reappointment;

(iv) to seek such additional information as is deemed necessary to make confident recommendations about applicants at the Medical Executive Committee meeting and to the Board

c. Succession

There shall be an immediate succession in the position of Chief of Staff Elect after his/her two year term as Chief of Staff Elect to serve as Chief of Staff. Additionally, the Chief of Staff shall immediately succeed to the Immediate Past Chief of Staff position prior to rotating off the Medical Executive Staff.

d. Members-at-Large of the Executive Committee

Members-at-large will be elected from the active Medical Staff to serve a term of two (2) years. No member may hold more than one office at any time. Elected members-at-large are not eligible for reelection to that office until a year after leaving that office. Elections and nominations for members-at-large will be the same as for officers under Section 10.3.

e. Meetings

The Medical Executive Committee shall meet at least quarterly and maintain a permanent record of its proceedings and actions.

11.3 PHARMACY AND THERAPEUTICS/DRUG USAGE EVALUATION COMMITTEE

Evaluation is designed to continuously improve the appropriate and effective use of drugs by utilizing a criteria-based, ongoing, planned and systematic process. This includes the routine collection and assessment of information to identify opportunities to improve the use of drugs and resolve problems in their use. Ongoing monitoring and evaluation of selected drugs chosen because the drug is frequently prescribed, known or suspected to present significant risk to patients, known or suspected to be problem prone or is a critical component of the care provided for a specific diagnosis, condition or procedure.

The process is performed by a representative(s) of Medical Staff appointed by the hospital administration and in cooperation with the hospital's Pharmacy Department, Nursing Administration, Administrative Staff and other affected departments or individuals. Review is based on objective criteria that reflect current knowledge, clinical experience and relevant literature and may include screening mechanisms to identify, for more intensive evaluation, problems in or opportunities to improve use of a specific drug or category of drugs. Review shall occur as often as necessary to accomplish meaningful evaluation, but no less than quarterly.

Results from drug usage evaluation will be reported at quarterly meetings, and will be used primarily to study and improve processes that affect the appropriate and effective use of drugs.

11.4 QUALITY MANAGEMENT COMMITTEE

The Quality Management Committee, appointed by the medical executive committee, meets quarterly, and addresses overutilization, under-utilization and inefficient scheduling of resources through a written plan approved by the Medical Staff, Administration and the Board. The committee structure is defined in a written plan. The following four aspects will be the minimum reviewed: the

appropriateness and medical necessity of admissions, whether the level of care or service needed by the patient can be provided by the Hospital, the clinical necessity of continued stay, and the appropriateness, clinical necessity, and timeliness of support services provided directly by the Hospital or through referral contracts.

A quarterly review of medical records is performed for clinical pertinence and timely completion. This function is performed by the Medical Staff in cooperation with Nursing Administration, the Medical Records Department and Administration.

Through a representative sample of records, this review assures that the diagnosis, results of diagnostic tests, therapy rendered, condition and in-hospital progress of the patient and condition of the patient and condition of the patient at discharge is accurately reflected in the record.

A quarterly review of summary information regarding timely completion of records will be evaluated, which will include suggestions to improve performance.

11.5 OTHER COMMITTEES AND FUNCTIONS

The Medical Executive Committee shall establish, modify or dissolve appropriate committees, other than those created by these Bylaws, by resolutions or policy, from time to time as needed, with appropriate composition, duties, meeting and reporting requirements. The Medical Executive Committee shall provide for the satisfaction of all functions and duties requiring Medical Staff involvement imposed by accreditation, licensure or other applicable requirements. Other committees or task forces may be formed or dissolved as necessary relating to interdisciplinary coordination and cooperation, quality improvement and education.

a. Infection Control

A multidisciplinary committee composed of representatives from the Medical Staff, Nursing Administration, Infection Control, and Administration will meet at least quarterly to oversee management of the infection surveillance, prevention and control program.

The committee will approve the type and scope of surveillance activities, to include review of microbiological reports, review of possible nosocomial infections, focus on those infections that present the potential for prevention or intervention to reduce the risk of future occurrence, prevalence and incidence studies and other routine or special collection of data.

The committee approves actions to prevent or control infection. At least

every two years, the committee reviews and approves all policies and procedures related to the Infection Control program.

The committee has the authority to institute any surveillance, prevention and control measures or studies when there is reason to believe that any patient or personnel may be in danger as defined in writing and approved by the Hospital Administration and Medical Staff.

b. Practitioner Health

The purpose of the Practitioner Health Committee is to protect patients, fellow practitioners, and other persons present in the hospital from harm by establishing mechanisms to monitor and treat any practitioner or Allied Health Professional (AHPs) with impairments which might negatively contribute to, or endanger the well-being of themselves or their patients.

The roles and responsibilities of the committee are as follows:

(1) Education
   a. Committee will inform all practitioners, AHPs, and staff about illness and impairment recognition issues specific to Licensed Independent Practitioners.

(2) Identification
   a. Committee will have in place a mechanism for practitioner self-referral
   b. Committee will have in place a mechanism by which other practitioners and staff may confidentially refer the committee to a practitioner who they know to have or suspect to have an impairment that might endanger a patient. The committee will evaluate the credibility of each complaint.
   c. Committee will maintain the confidentiality of any practitioner seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the health and safety of a patient is threatened.

(3) Investigation
   a. The committee will investigate the credibility of every complaint, allegation or concern brought to the committee's attention regarding a possible impairment of any practitioner or Allied Health Professional.

(4) Referral
   a. Committee will refer the affected practitioner to the appropriate professional internal and external resources for evaluation, diagnosis, and treatment of the condition or concern.

(5) Monitoring
   a. Committee will monitor the affected practitioner and safety of patients until the rehabilitation or any disciplinary process is complete and periodically thereafter, if required.

(6) Report

a. Committee must report instances in which any practitioner is providing unsafe treatment.

ARTICLE XII

COMMITTEE MEETINGS

12.1 REGULAR MEETINGS

Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

12.2 SPECIAL MEETINGS

A special meeting of any committee may be called by or at the request of the chairperson thereof, by the Chief of Staff of the Medical Staff, or by one third of the group's members, but not less than two members.

12.3 NOTICE OF MEETINGS

Written or oral notice stating the place, day and hour of any regular meeting not held pursuant to resolution shall be given to each member of the committee not less than ten (10) days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States Mail addressed to the member at his/her address as it appears on the records of the Hospital with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

12.4 QUORUM

A quorum is required for all committee meetings, including the Medical Executive Committee. A quorum shall be a minimum of three voting appointees to the committee.

12.5 MANNER OF ACTION

The action of a majority of the appointees present at a meeting at which a quorum is present shall be the action of a committee. Action may be taken within a meeting by unanimous consent in writing (setting forth the action so taken) signed by each appointee entitled to vote thereat.

12.6 RIGHTS OF EX-OFFICIO MEMBERS

Persons serving under these Bylaws as ex-officio members of a committee shall have all rights and privileges of regular members except they shall not vote.

12.7 MINUTES

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote on each matter. Each committee shall maintain a permanent file for the minutes of each meeting.

12.8 ATTENDANCE REQUIREMENTS

a. Any appointee to the active Medical Staff who is compelled to be absent from a committee meeting shall request that his/her absence be excused, either in writing or by telephoning the committee chairperson stating the reason for such absence. Excused absences will be limited to three committee meetings. The Medical Executive Committee shall have the authority to grant further excused absences on an individual basis. The failure to meet the foregoing annual attendance requirements shall be grounds for removal from such committee by the Medical Executive Committee. Removal from a committee on the grounds stated in this subsection will not entitle the Medical Staff member to a hearing. Committee chairpersons shall report all such failures to the Medical Executive Committee for action.

b. A practitioner whose patient's clinical course is scheduled for discussion at a committee meeting shall be given timely notification and shall be expected to attend such meeting.

c. Failure by a practitioner to attend any meeting with respect to which he/she was given notice that attendance was mandatory, unless excused by the chairperson upon a showing of good cause, could result in corrective action, if necessary. In all other cases, if the practitioner shall make a timely request for postponement supported by an adequate showing that his/her absence will be unavoidable, such presentation may be postponed by the Medical Executive Committee.

ARTICLE XIII

MEDICAL STAFF MEETINGS

13.1 THE ANNUAL MEETING

a. The annual meeting of the staff shall be at the last meeting of the calendar year. This meeting shall include a business section in which all standing committees shall be required to present a complete annual report.

b. The action of a majority of the appointees present at a meeting at which a quorum is present shall be the action of the Medical Staff. Action may be

taken within a meeting by unanimous consent in writing (setting forth the actions so taken) signed by each appointee entitled to vote.

c. Officers for the coming year shall be elected at the annual meeting.

13.2 GENERAL MEDICAL STAFF MEETINGS

a. Regular meetings of the entire Medical Staff shall be held at least annually at a time and place designated by the Medical Executive Committee for the transaction of business, the election of officers (when appropriate), and to inform the staff of professional topics of current interest.

b. In addition to matters of organization, the program of such meeting shall include a report of the Medical Executive Committee and other appropriate committees.

c. The sole objective of the Medical Staff meetings is to promote the improvement of the care and treatment of the patients in the Hospital.

13.3 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or at the request of the Medical Executive Committee.

13.4 QUORUM

Those active members of the Medical Staff at any regular or special meeting shall constitute a quorum for the transaction of all business of the Medical Staff.

13.5 ATTENDANCE REQUIREMENTS

All Medical Staff members are encouraged to attend all regular Medical Staff meetings in each year.

13.6 AGENDA

a. At any regular Medical Staff meeting the agenda shall be set by the Chief of Staff of the Medical Staff.

b. The agenda at special meetings shall be:

(1) Reading of the notice calling the meeting;

(2) Transaction of business for which the meeting was called; and

(3) Adjournment.

ARTICLE XIV
HISTORY AND PHYSICAL EXAMINATIONS

14.1 A history and physical examination must be dictated or documented in the patient's medical record by the patient's attending physician, a member of the house staff, a credentialed Advanced Registered Nurse practitioner (ARNP) or a Physician Assistant (PA), all under the attending physician's supervision. The history and physical must be available in the patient medical record on all inpatients within twenty-four (24) hours of admission and on all patients prior to surgery or procedure. The history and physical examination shall be countersigned by the attending physician.

14.2 The history and physical examination completed before admission is valid for thirty (30) days only, and must be updated with any changes (or state that no changes have occurred) within twenty-four (24) hours after admission, and prior to a surgery or procedure. A history or physical examination greater than thirty (30) days old cannot be updated, or referred to, in a current history and physical examination.

ARTICLE XV

RULES AND REGULATIONS

The Rules and Regulations may be amended by the MEC. Prior to amending the Rules and Regulations, the MEC must first communicate the proposed amendment to the Active Medical Staff for review and comment. This review and comment opportunity shall be accomplished by circulating the proposed amendment to all Active Medical Staff Members at least thirty (30) days prior to the scheduled MEC meeting, together with instructions on how interested Members may communicate their comments to the MEC. A comment period of at least fifteen (15) days shall be afforded, and all comments shall be summarized and provided to the MEC prior to the MEC's action on the proposed changes. The Rules and Regulations shall become effective after submittal and approval by the Board. The Rules and Regulations shall be reviewed on a regular basis.

ARTICLE XVI

AMENDMENTS TO THE BYLAWS

These Bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff.

To be adopted, an amendment shall require a two-thirds vote of the active Medical Staff present and voting, including those present by proxy votes properly executed under the terms of these Bylaws.

The Medical Executive Committee may from time to time submit Medical Staff issues, including revisions and amendments to these Bylaws and Rules and Regulations, to the

Medical Staff by mail, with a return written ballot or by email, with a return paper or electronic ballot. The Medical Executive Committee is authorized to adopt Rules and Regulations for the submission and processing of mail/email ballots. For an mailed or email amendment as described in his paragraph, to be adopted, the amendment shall require a two-thirds vote of the active Medical Staff eligible to vote. Ballots which are not returned by the indicated due date will be considered an affirmative vote by the Member.

Amendments so made pursuant to this Article XVI shall be effective when approved by the Board.

ARTICLE XVII

ADOPTION OF THE BYLAWS

These Bylaws shall be adopted at any regular or special meeting of the Medical Staff, and shall become effective when approved by the Board.

ADOPTED by the Medical Staff on **October 27, 2015.**

ADOPTED by the Board on **March 24, 2016**.

Chief of Staff of the Medical Staff

Chairman of the Board