COMMUNITY HOSPITAL EAST AND COMMUNITY HOSPITAL NORTH MEDICAL STAFF BYLAWS

VOLUME I
GOVERNANCE AND FUNCTION OF THE MEDICAL STAFF

Approved: Medical Executive Committee – May 19, 2015
Approved: General Medical Staff – July 7, 2015
Approved: Board of Directors – August 10, 2015
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DEFINITIONS

The terms defined in this volume of the Bylaws shall have the same meaning throughout all volumes of the Medical Staff Bylaws when the first letter(s) of those terms are capitalized, unless in context, the term is otherwise defined.

ADVERSE ACTION OR ADVERSE RECOMMENDATION means a Professional Review Action as defined by the Health Care Quality Improvement Act (“HCQIA”), that if approved by the governing board of the Hospital, will adversely affect the privileges or membership of a physician or dentist for a period of greater than thirty (30) days.

ADVERSELY AFFECTING means reduce, restrict, suspend, revoke, deny or fail to renew clinical privileges or membership for greater than thirty (30) days.

ADVERSE DECISION means a professional review action as defined by HCQIA in which the Board or MEC denies, terminates, limits, suspends, or modifies a grant of Privileges or Medical Staff membership for reasons related to unprofessional conduct or clinical competence.

ALLIED HEALTH PRACTITIONER or AHP means individuals other than physicians and dentists / oral surgeons, who exercise independent judgment within areas of individual professional competence and who are qualified to render patient care services in accordance with specific privileges granted and include, but shall not be limited to, psychologists, certified physician assistants, and advanced practice nurse practitioners.

BOARD, HOSPITAL BOARD or GOVERNING BOARD means the governing body of the Hospital.

BOARD CERTIFICATION: The designation conferred by one of the affiliated specialties of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the American Board of Oral and Maxillofacial Surgery, or American Board of Podiatric Surgery (ABPS) as applicable, upon a physician, dentist, or podiatrist who has successfully completed an approved educational training program and an evaluation process, including passing an examination. When used in the context of a credentialing process, the Board Certification may be required to be in a specific area of clinical practice.

BYLAWS: The governance documents which provide the framework for the organization of the Medical Staff, including its responsibilities, and mechanisms for self-governance. The Medical Staff Bylaws consists of three volumes: Volume I -- Governance and Functions of the Medical Staff; Volume II -- Investigation, Corrective Action, Hearing and Appeal Procedures of the Medical Staff; and Volume III -- Credentials Procedures of the Medical Staff.

CHAIR: The individual responsible for directing the functions and meetings of a clinical service or a Medical Staff committee.

CHIEF EXECUTIVE OFFICER (CEO): The individual appointed by the Board to act on its behalf in the overall administrative management of the Hospital

PRESIDENT OF THE MEDICAL STAFF (President): The elected leader of the Active Medical Staff.

CREDENTIALS COMMITTEE: means the professional review body composed of a majority of Active Members and which reviews qualifications of applicants for appointment and reappointment to the medical staff and requests for Privileges, makes recommendations regarding membership and the delineation of Privileges, and recommends the criteria for determining the Privileges to be granted and policies and procedures related to the credentialing of Practitioners.

DATE OF RECEIPT: The date any Notice, Special Notice, or other communication is delivered personally, by facsimile, or by electronic mail (email); or if such Notice, Special Notice, or communication was sent by
mail, it shall mean 72 hours after the Notice, Special Notice, or communication was deposited, postage prepaid, in the United States mail.

**DAYS:** Calendar days, unless otherwise noted.

**DELEGATION OF FUNCTIONS** means when a function is to be carried out by a person or committee, the person, or the committee through its Chair, may delegate performance of the function to one or more qualified designees.

**DENTIST:** A dentist or oral surgeon holding a D.D.S., D.M.D., or equivalent degree and a valid license to practice dentistry in the State of Indiana.

**EX OFFICIO** means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means *with* voting rights.

**HOSPITAL** means Community Hospital East and Community Hospital North and includes all of its facilities and all of its personnel and organizational entities, including the Medical Staff.

**HEALTH SYSTEM** means the Community Hospital East and Community Hospital North, The Indiana Heart Hospital, Community Hospital South, Community Hospital Anderson and affiliated clinical entities.

**JOINT CONFERENCE:** Defined as a meeting between representatives of the Board and representatives of the Medical Staff.

**MEDICAL EXECUTIVE COMMITTEE (MEC)** means the committee to whom the Medical Staff has delegated the authority to carry out medical staff responsibilities as set forth in Section 7.4 of Volume I.

**MEDICAL STAFF or STAFF:** means those physicians, dentists and oral surgeons appointed to the active, associate and honorary staff. All other practitioners, including residents, even though authorized by the board to exercise Privileges are not part of the Medical Staff.

**MEDICAL STAFF YEAR:** means the period from March 1 to February 28 or 29 of each calendar year.

**MEMBER:** means a Physician or Dentist who has been appointed by the Board to the Medical Staff.

**MONTHLY:** means each month of the calendar year. However, committees required to meet monthly shall hold at least ten (10) meetings in a calendar year but need not hold twelve (12) meetings.

**NOTICE:** A written or electronically transmitted communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or Hospital.

**ORGANIZED HEALTH CARE ARRANGEMENT:** A clinically integrated care setting in which individuals typically receive health care from more than one provider and which is defined in 45 C.F.R. §164.501 commonly known as the HIPAA Privacy Regulations.

**PATIENT CONTACT:** Any inpatient admission, inpatient consultation, inpatient or outpatient referral or inpatient or outpatient procedure performed in the Hospital.

**PEER REVIEW:** means evaluation of (i) the qualifications, (2) patient care rendered by, or (3) merits of a complaint against any professional health care provider as defined by Ind. Code 34-6-2-117 or any successor legislation.
**PEER REVIEW COMMITTEE:** means a peer review committee as defined by Ind. Code 34-6-2-99.

**PHYSICIAN:** An individual with an M.D. or D.O., degree who is licensed to practice in the State of Indiana.

**POLICIES:** All Medical Staff and Hospital policies referred to in the Medical Staff Bylaws can be obtained through the Medical Staff office of the Hospital.

**PRACTITIONER:** means any physician, dentist, advanced practice nurse practitioner, podiatrist, psychiatrist, clinical psychologists or other practitioner granted Privileges by the Board under these Bylaws or those applicable to their profession.

**PRIVILEGE:** The permission granted by the Board to a Practitioner to render or exercise specific diagnostic, therapeutic, medical, surgical or dental services and/or procedures in the Hospital or any of its facilities.

**PRONOUNS:** The use of the male pronoun (he/his/him) throughout these Bylaws is applicable to either male or female individuals.

**RULES & REGULATIONS:** Are Medical Staff policies and procedures approved by the MEC and ratified by the Board.

**SPECIAL NOTICE:** Written notification sent by hand delivery, or by certified or registered mail return receipt requested.

**TIME LIMITS:** All time limits referred to in these Bylaws and other Medical Staff policies and procedures are advisory only, and are not mandatory unless a specific provision states that a particular right is waived by failing to take action within a specified time period.
ARTICLE I.
PURPOSE OF ORGANIZATION

The purpose of this Medical Staff is to strive for excellence in patient care and community health. The Medical Staff is accountable to the Board for the quality of medical care provided to patients in the hospital and accepts and discharges this responsibility as described in these Bylaws and associated documentation, subject to the ultimate authority of the Hospital's Board. The Medical Executive Committee (MEC), the Medical Staff and any of their committees or agents, in order to promote professional peer review activity designed to establish a collegial environment in which appropriate standards of medical care may be achieved, constitute themselves as professional peer review bodies as defined in the Health Care Quality Improvement Act of 1986 and as peer review committees as defined by the Indiana Peer Review Act, and claim all the privileges and immunities of those acts. The Medical Staff is considered part of an Organized Health Care Arrangement.

ARTICLE II.
MEDICAL STAFF MEMBERSHIP & CATEGORIES

SECTION 2.1 Eligibility and Qualification of Membership.
Membership on the Medical Staff is a privilege granted only to professional competent Physicians and Dentists who continuously meet the qualifications, standards and requirements set forth in these Bylaws and in Medical Staff and Hospital policies.

To be eligible to apply for initial appointment or reappointment to the Medical Staff of the Hospital applications must hold a license to practice in the State of Indiana as a Doctor of Medicine, Doctor of Osteopathy, or Dentist with a Doctor of Dental Medicine or Dental Surgery degree. Applicants to the Medical Staff have the burden of documenting to the satisfaction of the Board that they will contribute to meeting the mission of the Hospital and have the ability to do so competently, safely, and collaboratively by providing requested information on their:

(a) Background
(b) Clinical Experience
(c) Education and Training
(d) Clinical Judgment
(e) Demonstrated professional competence
(f) Individual Character and ability to work with others collaboratively
(g) Physical and mental capabilities and ability to safely and competently exercise any clinical privileges requested
(h) Intended practice plans

Additional membership and privileging requirements considered associated details can be found in Volume III of these Bylaws and the Medical Staff's delineation of privilege forms.

A Physician or Dentist who does not meet the basic qualifications is ineligible to apply for Medical Staff membership and the application shall not be processed. The qualification for membership must be documented with sufficient adequacy to satisfy the Medical Staff and Board that each has enough information to make a fully informed decision regarding appointment and assignment of privileges.

No professional may be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of licensure to practice in Indiana or any other state, membership in any professional organization, certification by any American Board of Medical Specialty, privileges at another Hospital, or the demonstration of clinical competence.

No person shall be appointed to the Medical Staff if the Board, at its sole direction, is unable to provide adequate facilities and support services for the applicant or his patients.
The Board may make exceptions or additions to any of the above qualifications and requirements after obtaining consultation and a recommendation from the Medical Executive Committee (MEC).

SECTION 2.2. NON-DISCRIMINATION. The Hospital will not discriminate in granting of Medical Staff membership and/or clinical privileges on the basis of gender, race, religion, national origin, disability unrelated to the provision of patient care or required Medical Staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

SECTION 2.3. CATEGORIES OF MEDICAL STAFF MEMBERSHIP. The Medical Staff shall be divided into the following categories: Active, Associate and Honorary. Category status for each Physician or Dentist will be recommended by the Credentials Committee and the MEC at appointment or reappointment and approved by the Board.

2.3.1. ACTIVE STAFF.

(a) QUALIFICATIONS: Appointees to this category must:
   i. Be involved in a minimum of twenty-four (24) Patient Contacts at the Hospital, over a 24 month period. Members may be appointed to this category at initial appointment where it is anticipated they will meet this criterion. If they have not completed 12 Patient Contacts in their first twelve months on staff, their category status will be changed to Associate. Otherwise after initial appointment, category status will be assigned at reappointment time based on Patient Contact activity during the previous 24-month period or at any time by request of the medical staff Member. Where a member brings particular skills, contributions, or a benefits to the Hospital and Medical Staff, the Board may appoint to the Active category ever where an individual does not meet the minimum activity requirements.

(b) PREROGATIVES: Appointees to this category may:
   i. Exercise clinical Privileges granted by the Board
   ii. Vote on all matters presented at general and special meetings of the Medical Staff, and at meetings of clinical services (s) and committees to which he/she is appointed.
   iii. Hold office and sit on or act as chair of any committee, unless otherwise specified elsewhere in these Bylaws.

(c) RESPONSIBILITIES: Appointees to this category must:
   i. Meet the Basic responsibilities of Medical Staff Membership, as defined in Volume I, Article II, Section 2.4, and contribute to the organization and administrative affairs of the Medical Staff.
   ii. Actively Participate in recognized functions of staff appointment, including performance improvement, peer review, risk and utilization management, the monitoring of initial appointees, credentialing activities, medical records completion, and the discharge of other Medical Staff functions and clinical service obligations as may be required from time to time.
   iii. Comply with all Hospital and Medical Staff policies and procedures.
   iv. Participate in providing emergency room call for individuals with no stated physician-related relationship with an existing Member and in other coverage arrangements as defined in policies adopted by the MEC and the Board.
   v. Perform such further duties as may be required under there Bylaws or Medical Staff policies, including any future changes to these documents.

2.3.2. ASSOCIATE STAFF.

(a) QUALIFICATIONS: Appointees to this category must:
   i. Be interested in the clinical affairs of the Hospital and hold Privileges to actively manage patient care or to refer and follow hospitalized patients.
ii. Admit or otherwise be involved in the care or treatment of less than 24 Patient Contacts (as defined in Section 2.3.1 under the Active Category) in an appointment period.

iii. Engage in the active practice of medicine at some location so that the Medical Staff and Board can assess the Practitioner’s compliance with membership and privileging requirements as stated under these Bylaws and Medical Staff policies. At each reappointment time, the associate staff Member may be asked to provide evidence of clinical performance at other hospitals where the Member holds privileges. In addition, especially for those Associate Staff members who do not maintain appointment at another hospital, he shall provide other information as may be requested by the Medical Staff or Board in order to perform an appropriate evaluation of qualifications. Such information may include but will not be limited to, data from the Member’s office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluations forms completed by a physician serving as a professional reference.

(b) PREROGATIVES: Appointees to this category may:
   i. Exercise those Privileges granted by the Board.
   ii. Attend meetings, without vote, of the general medical staff and the clinical service to which he/she is appointed. An Associate Member may attend and vote on Medical Staff committees to which the member is appointed. Associate members may attend all educational programs presented by the Medical Staff and/or Hospital.
   iii. Not vote or hold a Medical Staff Office or Clinical Service Chair position within the Medical Staff organization.

(c) RESPONSIBILITIES: Appointees to this category may:
   i. Meet the basic responsibilities of Medical Staff membership, as defined in Article 2.3, and contribute to the organizational and administrative affairs of the Medical Staff.
   ii. Actively participate, when asked, in recognized functions of staff appointment, including performance improvement, peer review, risk and utilization management, the monitoring of initial appointees, credentialing activities, medical records completion, and the discharge of other Medical Staff functions and clinical service obligations as may be required from time to time.
   iii. Comply with all applicable Hospital and Medical Staff policies and procedures
   iv. Participate in providing emergency room call for individuals with no stated physician-patient relationship with an existing Member and other coverage arrangements as defined in policies adopted by the MEC and the Board.
   v. Perform such further duties as may be required under these Bylaws or Medical Staff Policies, including any future changes to these documents.

2.3.3. HONORARY MEDICAL STAFF. The Honorary Staff Category is restricted to those individuals the Medical Staff wished to honor. Criteria for this Category includes, but is not limited to, those Members who have activity participated in Hospital affairs, committee activity and who may have had a Medical Staff Leadership role. The Clinical Service Line Chair or the MEC may forward the names of members being considered for this category and will submit a recommendation to the MEC for consideration and decision. Such staff appointees are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital, nor vote at any meetings attended. Honorary Staff may, however, attend Medical Staff and clinical service meetings and educational programs. They may also be appointed as non-voting members of committees where interested so that the Medical staff may take advantage of their unique experience or talents.

(a) PREROGATIVES: Members in the Honorary Medical Staff Category shall be invited and welcome to attend education and social functions of the Hospital and Medical Staff as appropriate.

(b) RESPONSIBILITIES: Members in the Honorary Medical Staff category will conduct themselves at all times in a manner that will not diminish or tarnish the reputation of the Medical Staff or the Hospital.
2.3.4. CHANGE IN STAFF CATEGORY. Pursuant to a request by the Medical Staff member, upon a recommendation by the Credentials Committee, or pursuant to its own action, the MEC may recommend by the Credentials Committee, or pursuant to its own action, the MEC may recommend a change in medical staff category of a member consistent with the requirements of these Bylaws. The Board shall approve any change in category. Determinations based on failing to satisfy the threshold eligibility requirement of a certain number of Patient Contacts regarding assignment of Medical Staff Category do not trigger any formal hearing or appeal procedures set forth in Volume II. Of the Bylaws; however, the Member may request an audience with the Credentials Committee.

2.3.5. LIMITATION OF PREROGATIVES. The prerogatives of Medical Staff membership set forth in these Bylaws are general in nature and may be subject to limitation or restriction by special conditions attached to a Members’ appointment, reappointment, or Member’s or Practitioner’s Privileges, by state or federal law or regulations, by other provisions of these Bylaws or by other Medical Staff and Hospital policies, or by commitments, contracts or agreements of the Hospital.

SECTION 2.4. RESPONSIBILITIES OF MEMBERSHIP. Each member of the Medical Staff must continuously comply with the provisions of these Bylaws, Medical Staff or Hospital policies, procedures or rules and regulations. Members must:

(a) Provide continuous and timely care to all patients for whom the individual has responsibility as determined by the MEC with input from the appropriate clinical specialty;
(b) Provide with or without request, new and updated information to the Hospital as it occurs, pertinent to any question found on the initial application or reappointment forms;
(c) Appear for personal interviews (in person or by teleconference) in regard to an application for initial appointment or reappointment, as requested by the appropriate Medical Staff committee;
(d) Refrain illegal fee splitting or other illegal inducements relating to patient referrals;
(e) Refrain from deceiving patients as to your identity or the identity of any other individual providing treatment or services;
(f) Seek appropriate consultation, consistent with community standard, to assure adequate quality of care;
(g) Complete in a timely manner all required entries into medical and other required records, including conducting and documenting a physical examination and medical history for each patient no more than thirty days before or 24 hours after admission or registration. A history and physical examination must be completed and documented prior to any examination or completed within the 30 days prior to admission, they must be updated within 24 hours of admission by a physician or qualified licensed individual. The updated examination must be completed and documented within 24 hours after admission or registration, noting any changes in the patient’s condition;
(h) Satisfy continuing medical education requirements for licensure and as may be required under policies adopted from time to time by the Medical Staff;
(i) Supervise the work of any allied health professional under his/her supervision;
(j) Assist other Practitioners in the care of their patients when asked in order to meet an urgent patient need or assure the well-being of a patient;
(k) Encouraging, when appropriate, the consent of the appropriate representative of a deceased patient to an autopsy.
(l) Conform to the Code of Conduct, ethics of the Medical Staff, the Hospital compliance program
(m) Furthermore, each Member of the Medical Staff by accepting Medical Staff appointment, agrees:
   i. To abide by these Bylaws, all supplemental Medical Staff or Hospital policies, procedures and rules and regulations.
   ii. To participate in and collaborate with the peer review and performance improvement activities of the Medical Staff or the Hospital. These include monitoring and evaluation tasks performed by the Medical Staff and compliance with Hospital efforts to meet standards such as those established by the Joint Commission, insurers, Centers for Medicare and Medicaid Services (CMS) and other governmental agencies (e.g. core measures);
iii. To assist the Hospital in fulfilling its responsibilities for providing emergency and charitable care in accordance with policies passed by the MEC and Board;

iv. To permit the Hospital and Medical Staff to share peer review, credentialing/privileging and performance information with any related healthcare entity affiliated and the Health system at which the Member holds or seeks membership and/or privileges at which the Hospital has entered into a written agreement to share such information (nothing in this section prevents Hospital from providing such information when allowed under Indiana Law);

v. To undergo any type of health evaluation by a consultant selected by the Hospital, including drug testing, as requested by the President of the Medical Staff and/or MEC, and/or the Hospital President or designee in consultation with the President of the Medical Staff when it appears necessary to protect the well-being of patients and/or staff; or when requested by the MEC or Credentials Committee as part of an evaluation of the Member’s ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and Hospital policies addressing physician health or impairment.

vi. To participate in any type of competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate that member’s clinical privileges.

vii. To provide patient care and management only within the parameters of his professional competence, as reflected in the scope of clinical Privileges granted by the Practitioner by the Board.

viii. To hold harmless and agree to refrain from legal action against any individual, the Medical Staff or Hospital that appropriately shares peer review and performance information with another health care entity assessing the credentials, performance or conduct of the Member or state medical or dental board.

ix. Abide by all local, state and federal laws and regulations, the Joint Commission (TJC) Standards, and state licensure and professional review regulations and standards, as applicable to the Practitioner’s professional practice.

Section 2.5. BILL OF RIGHTS.

2.5.1. PROFESSIONAL CONDUCT. The professional conduct of the physician and dentist Members of the Medical Staff shall be judged by the Code of Conduct Policy adopted by the Medical staff.

2.5.2. FAIR HEARING. Any member aggrieved by an adverse recommendation that if approved by the Board will adversely affect appointment, reappointment or clinical Privileges for more than thirty (30) days has the right to a hearing appeal under Volume II. Of the Bylaws, unless such right has been specifically excluded or waived under these Bylaws.

2.5.3. IMMUNITY FROM LIABILITY. There shall be, to the fullest extent permitted by law, immunity from civil liability arising from any act, communication, report, recommendation or disclosure performed at the request of an authorized member of the Hospital, Medical Staff or any other healthcare facility or regulating agency for the purpose of improving performance of the Practitioner or maintaining the quality of patient care.

2.5.4. RIGHT OF NOTIFICATION. Except as required to protect patient safety or prevent disruption to the operation of the Hospital, any Member will be notified before a formal investigation is initiated by the MEC, the Quality Assurance Council of the MEC and/or the President on any matter of performance or conduct which could result in denial, suspension or reduction in privileges.

2.5.5. ACCESS TO COMMITTEES. Members are entitled to be present at any committee meeting except during professional or peer review activities or proceedings.
2.5.6. COMMUNICATION AND INFLUENCE WITH MEC. Each member has the right to meet with the MEC on matters relevant to the responsibilities of the MEC. In the event that the President determines that such Member is unable to resolve a matter of concern after discussion with the appropriate with the appropriate clinical service or committee chair or other appropriate Medical Staff leader(s), that Member may, upon written Notice to and approval of the President at least two weeks in advance of a regular meeting of the MEC, meet with the MEC or MEC subcommittee to discuss the issue. The President will have discretion regarding the meeting date, timing and placement of the issue on the MEC agenda or direction of the issue to a subcommittee.

2.5.7. RIGHT TO INFORMATION. Members are entitled to be informed of certain non-privileged and confidential Medical Staff information and developments. The MEC will publish and post on the Medical Staff website, and notify electronically, one month in advance of the MEC vote: all Member candidates to review and comment on; any pending or proposed changes to the Bylaws, and Medical Staff Policies and Procedures.

2.5.8. ACCESS TO CREDENTIALS FILES. Each Member shall be allowed an opportunity to receive his own credentials or peer review/clinical performance file in the manner consistent with the Credentials Procedures in Volume III, of these Bylaws.

2.5.9. CONFIDENTIALLY. Matters discussed in committee deemed to be confidential, and otherwise undertaken in the performance of Medical Staff duties and privileges shall remain confidential.

2.5.10. RECALL OF ELECTED LEADERS. Any Active Member of the Medical Staff has the right to initiate a recall vote of a Medical Staff Officer(s) or Clinical Service Chair in accordance with the recall provisions provided in these Bylaws.

2.5.11. RIGHT TO ASSEMBLE. Any Member of the Medical Staff may call for a clinical service meeting by presenting a petition stating the clear purpose of the meeting signed by twenty-five percent (25%) of the Members of the Clinical Service. Upon presentation of such a petition, the clinical service chair will schedule a clinical service meeting within forty-five (45) days to discuss the concerns raised by the petitioners.

Each member of the Active Category may call for a general medical staff meeting to discuss a matter relevant to the Medical Staff by presenting a petition to the President of the Medical Staff, signed by Twenty Percent (20%) of the Members of the Active Category. Upon receipt of and verification of such signed petition, the President or in the absence of the President, the highest available Officer of the MEC Shall schedule a general staff meeting within forty-five (45) days for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted. Any recommendations by the majority of the voting Active Staff Members made at the special meeting shall be forwarded to the MEC for action. If the recommendation of the MEC varies from the recommendation from the general medical staff meeting, the issue will be referred to a special or general meeting of the Medical Staff for resolution.

2.5.12. MEMBER RIGHTS. The above sections on Member Rights (2.5.1 through 2.5.11) do not pertain to issues involving peer review, performance improvement efforts and performance evaluations (including focused and ongoing professional practice evaluations), Investigations of professional performance or conduct, denial or requests for appointment or privileges, restriction or conditions placed on appointment or privileges, or any other matter relating to individual membership or privileges. Recourse with regard to these matters is described in Volume II of these Bylaws.

ARTICLE III.
DETERMINATION OF PRIVILEGES

SECTION 3.1. EXERCISE OF PRIVILEGES. Physician, Dentists or Practitioners providing clinical services at the Hospital shall be entitled to exercise only those Privileges specifically granted to them by the Board, or emergency or disaster Privileges as described in these Credentials Procedures.
SECTION 3.2. Delineation of Privileges in General

3.2.1. REQUESTS. Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical Privileges desired by the applicant. Practitioners who are ineligible for Medical Staff Membership may apply for Privileges by requesting an application form from the Medical Staff Office. A request by a Physician, Dentist, Podiatrist or Practitioner for Privileges or the modification of Privileges must be supported by all requested documentation regarding appropriate licensure, training and the evidence of current competence. Privilege requests will not be processed where the applicant does not meet the eligibility requirements to be granted the privilege at Community Hospitals.

3.2.2. BASIS FOR DETERMINATION OF PRIVILEGES. Privileges shall be determined on the basis of the Physician’s, Dentist’s, Podiatrist’s or Practitioners prior and continuing education, training, experience, utilization patterns and demonstrated current competence, including observed professional performance and documented results of individual’s specific performance improvement activities. Information concerning professional performance obtained from other sources will be considered when available, especially from other institutions and health care settings where a Physician, Dentist, Podiatrist or Practitioner exercises Privileges. It is the burden of the Physician, Dentist, Podiatrist or Practitioner applying for Privileges to provide all information requested by the Medical Staff and Board as they determined necessary to evaluate the request.

All Postgraduate trainees (residents, fellows, visiting fellows) under GME administration (either an approved ACGME/AOA/CEP program or a network approved program) and acting under the auspices of that program will not be required to request specific Privileges, unless required by the Community Hospitals’ accrediting body. They must carry out any clinical care in accordance with the written educational protocols developed by the GME office and approved by GMEC, and their training program. These protocols must delineate the roles, responsibilities, and scope of clinical activities application to such trainees. They must also describe the requirements for oversight of trainees, the types of orders they may write, and when such orders must be countersigned and by whom. The protocols will describe how trainees’ level of responsibility and scope of practice may expand over time and how this information will be transmitted to staff and personnel working in the Hospital. These protocols must be periodically reviewed and approved by the MEC. In addition, training programs will periodically communicate with the MEC regarding the performance of its trainees and alert to any performance concerns or matters that may threaten patient safety. GMEC will report annually to the Medical Executive Committee. The training program must work with the MEC to ensure that all supervising Members hold Privileges commensurate with their oversite activities.

3.2.3. PROCEDURE. All requests for clinical Privileges shall be processed pursuant to the procedures outlined in the Bylaws and Medical Staff policies. Request for Privileges will not be processed where the Board has made a determination that the Hospital will not support or authorize the exercise of a particular privilege for any Physician, Dentist, Podiatrist or Practitioner at the Hospital; where the privilege requested is covered by an exclusive contract granted by the Board and the requesting Physician, Dentist, Podiatrist or Practitioner is not a party to the contract or provider under the contract; or where the requesting Physician, Dentist, Podiatrist or Practitioner does not meet the eligibility requirements to request or exercise a privilege as described in the Hospital’s Delineation of Privileges documents.

3.2.4. NEW TECHNOLOGY OR CROSS-SPECIALTY PRIVILEGES. In the event a Physician, Dentist, Podiatrist or Practitioner requests a privilege for which the Hospital has not adopted criteria (e.g. for a new technology, procedure, modality or multi/cross-specialty privilege), the request may be tabled for a reasonable period of time, usually not in excess of ninety calendar days. During this time the MEC and Board will review the community, patient, and Hospital need for the Privilege and determine if the institution can make available the necessary resources to adequately support the exercise of that Privilege. Senior management will resolve any non-exclusive or exclusive contract issues as appropriate to avoid violating the contract provisions. The Clinical Services will research appropriate eligibility criteria for the safe and effective exercise of the requested Privilege and establish, with input of the MEC and approval by the Board, the necessary education, training, experience
and evidence of current competence that will be required to request and be granted the privilege. Once these steps are taken, a request for the Privilege will be evaluated.

The process to be used in determining if a procedure, modality of care or treatment requires new/updated/different competency criteria prior to being eligible to request and be granted the privilege by the Board is as follows:

When the Clinical Service Chair, or two (2) or more members of the Credentials Committee determine that two (2) or more of the following criteria are significantly different than the current privilege, new/additional competency criteria will be developed by the Credentials Committee: skill, knowledge, technique, equipment, risk, judgment or ability to manage complications the procedure, modality of care or treatment.

3.2.5. Members without privileges for a particular treatment or procedure may refer patient to a Practitioner holding such privileges, and may follow such patients, but cannot write orders or manage patient care related to treatment.

**SECTION 3.3. CONFIRMATION OF COMPETENCY TO HOLD PRIVILEGES.** All privileges that are initially requested by new applicants or existing members of the Medical Staff are provided a time limited period of focused professional practice evaluation (FPPE). The Credentials Committee, after receiving a report from the Clinical Service Chair will define the conditions that warrant review/evaluation of the performance of each Physician, Dentist or Practitioner as part of the initial grant of clinical privileges at the hospital. Review and monitoring may utilize retrospective, prospective, or concurrent review, including but not limited to: chart review, the monitoring and review of performance (factors) or indicators, external peer review, simulations, clinical reviews, and discussion with other healthcare individuals who have observed and/or participated in patient care with the Physician, Dentist or Practitioner. The Credentials Committee will define the duration of the FPPE and the triggers that indicate the need for performance review and evaluation.

The Medial Staff participates in ongoing professional practice evaluation (OPPE) to identify Physician, Dentist or Practitioner practice outcomes and trends that impact the safety and quality of patient care. Information from the OPPE process will be used by leaders to determine if existing privileges are maintained, revised or revoked prior to or at the time of reappointment. The OPPE is part of the Medical Staff's evaluation, measurement, and improvement of Physician, Dentist or Practitioner's current clinical competency. In addition, each Physician, Dentist or Practitioner may be subject to a FPPE when issues affecting the provision of safe, high quality patient care are identified. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

**SECTION 3.4. TEMPORARY CLINICAL PRIVILEGES:**

3.4.1. CIRCUMSTANCES. Upon submission of a complete application that has been verified by the Medical Staff Office, temporary Privileges may be granted to a Physician, Dentist or Practitioner to provide for an important patient care need for a limited time, up to 120 days. Temporary privileges may be granted on a case-to-case basis when an important patient care need or service mandates an immediate authorization to practice. Temporary privileges may be granted to a Physician, Dentist or Practitioner upon the recommendation of the Medical Staff President or designee and who meets on of the following circumstances and the minimum criteria as defined below:

(a) **PENDENCY OF APPLICATION.** Temporary clinical privileges may be granted for permanent Medical Staff Membership and privileges, provided the application is complete, the applicant has no current or previously successful challenge to professional licensure or registration, no involuntary termination of Medical Staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges. All required verifications and processes as outlined in Volume III, Article II must be completed and the application is awaiting review and recommendation of the Medical Executive
Committee. Such persons may only attend patients for a period not to exceed 120 days.

(b) **CARE OF SPECIFIC PATIENTS.** In special circumstances upon receipt of a written request for specific temporary Privileges an appropriately licensed Physician, Dentist or Practitioner of documented competence, who is not an applicant for membership, may be granted temporary Privileges for the care of one or more specific patients. The following documentation is required for temporary privileges:

   i. Unrestricted Indiana State License
   ii. Unrestricted Federal DEA
   iii. Controlled Substance Registration (CSR)
   iv. Current valid professional liability insurance coverage in a certificate form and in amounts satisfactory to the Hospital
   v. Current standing from primary practicing facility
   vi. National Practitioner Data Bank report (processed by the Hospital)
   vii. A verbal, written or electronic reference which establishes current competency

(c) **LOCUM TENENS.** Upon receipt of a complete application that has been verified by the Medical Staff Office, and a written request for specific temporary Privileges, an appropriately licensed Physician, Dentist or Practitioner of documented competence who is serving as a Locum Tenens for a member of the Medical Staff may, without applying for membership on the Staff, be granted temporary Privileges for an initial 120 days. A Locum Tenens physician shall be limited to treatment of the patients of the Physician, Dentist or Practitioner for whom he/she is serving a Locum Tenens. A Locum Tenens Physician shall not be entitled to admit his/her own patients to the Hospital unless such Privileges are specifically granted. This request must be accompanied by a written statement from the affected Medical Staff member that he/she is utilizing the applicant Physician, Dentist or Practitioner as a Locum Tenens.

3.4.2. **CONDITIONS.** Temporary privileges shall be granted by the Hospital President/CEO or designee acting on behalf of the Board and based on a recommendation of the Medical Staff President or designee. Before temporary privileges are granted, the Physician, Dentist or Practitioner must acknowledge in writing that he/she has received and read copies of the Medical Staff Bylaws and all other Medical Staff and Hospital policies relevant to his/her performance of temporary Privileges, and that he/she agrees to be bound by them.

3.4.3. **TERMINATION.** On discovery of any information or the occurrence of any event of a nature which raises questions about a Physician, Dentist or Practitioner’s professional qualifications or ability to exercise any or all of the temporary Privileges granted, the Medical Staff President or designee, may terminate any or all of such Physician, Dentist or Practitioner’s temporary Privileges, subject to the approval of the CEO or designee acting on behalf of the Board. Where the life or well-being of a patient is determined to be endangered by continued treatment by a Physician, Dentist or Practitioner exercising temporary Privileges, the termination may be effected by any person entitled to impose precautionary suspensions under the Bylaws. In the event of such termination, the patients of such Physician, Dentist or Practitioner then in the Hospital shall be assigned to another Physician, Dentist or Practitioner by the Medical Staff President or designee. Where feasible, the wishes of the patient shall be considered in choosing a substitute Physician, Dentist or Practitioner.

3.4.4. **PROCEDURAL RIGHTS.** A Physician, Dentist or Practitioner shall not be entitled to procedural rights because of the denial of any request for temporary Privileges, or because of any termination or suspension of temporary Privileges, whether in whole or in part, unless based on a determination of demonstrated incompetence or unprofessional conduct.

**SECTION 3.5. EMERGENCY PRIVILEGES:** In case of an emergency any Medical Staff member attending a patient shall be expected and permitted to do everything in his/her power and to the degree permitted by his or her license, to save the life of the patient or prevent significant and disabling morbidity regardless of the member’s Medical Staff status, Clinical Service affiliation or Privileges. This duty shall be subject to the Medical Staff member’s concurrent duty to take into account or abide by a patient’s directive under the Indiana law to withhold or withdraw life-sustaining procedures or to take into account and abide by the requirements of sound medical practice. For purposes of this section, an emergency is defined as a condition or set of circumstances in...
which any delay in administering treatment would increase the danger to the patient’s life or the danger of serious harm. When such an emergency situation no longer exists, the patient shall be assigned to an appropriate member of the Medical Staff who holds Privileges appropriate to address the patient’s medical conditions.

SECTION 3.6. DISASTER PRIVILEGES.

3.6.1. AUTHORITY. The authority to implement disaster Privileges is at the direction of the Hospital Command Center, in consultation with the Medical Staff leadership, in the event the Emergency Management Plan is activated and the Hospital is unable to handle immediate patient care needs. One of the following individuals may grant disaster Privileges once appropriate identification is obtained from a physician who has offered to volunteer during a disaster.

(a) CEO or designee
(b) Medical Staff President or any elected Officer of the Medical Staff
(c) Credentials Chair

3.6.2 ELIGIBLE PHYSICIAN. Disaster Privileges ay be granted only to physicians, who hold a license in the State of Indiana to practice medicine and who volunteer their services but to not possess Medical Staff Privileges at Community Hospitals

Primary source verification of licensure will begin as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer physician presents to the Hospital. Primary source verification applies only to volunteer physicians who provided care, treatment and services while under disaster Privileges.

In extraordinary circumstance in which primary source verification cannot be completed within 72 hours, it will be completed as soon as possible. Reason for the Hospital’s inability to verify will be documented with the following:

(a) Reason primary source verification not completed in the specified time period;
(b) Evidence of a demonstrated ability to continue to provide adequate care, treatment, and series; and
(c) Attempts to rectify the situation as soon as possible.

3.6.3. SCOPE OF PRIVILEGES. Volunteering physicians shall be paired with and supervised by a currently credentialed Medical Staff member. An approved form of ID must be worn at all times while volunteering at the Hospital. Scope of Privileges for the volunteering physician shall be consistent with minimum core Privileges and as determined by the onsite-supervising physician.

Within 72 hours of disaster Privileges being granted by the Medical Staff leadership will make a determination of the professional practice of the volunteer physicians and the need for continuation of disaster Privileges granted.

3.6.4. TERMINATION OF PRIVILEGES. Disaster Privileges will be for the duration of emergency situation. Privileges will automatically be canceled when it is determined by the Hospital that an emergency situation no longer exists. In the event that any information received through the verification process or the professional practice review indicates adverse information suggesting the person is not capable of rendering services in an emergency such Privileges shall be immediately terminated.

SECTION 3.7. TELEMEDICINE PRIVILEGES. Telemedicine Staff privileges shall be granted to licensed independent Physician, Dentist or Practitioners who have either total or shared responsibilities for patient care, treatment and services through a teledicine link.

All licensed independent Physicians, Dentist or Practitioners who provide services via teledicine link shall be credentialed and privileged to do so at the Community Hospitals using the credentialing and privileging
information from the distant site, to the extent allowed. In order to make final privileging decision, all the following requirements shall be met:

(a) The distant site is a Joint Commission accredited hospital or ambulatory care organization.
(b) The Physician, Dentist or Practitioner is privileged at the distant site for those services to be provided at the Hospital.
(c) The Hospital has evidence of an internal review by the distant site of the Physician, Dentist or Practitioner's performance of these privileges and sends to the distant site information that is useful to assess the Physician, Dentists or Practitioners quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information shall include all adverse outcomes related to sentinel events considered reviewable by the Joint Commission that result from the telemedicine services provided, as well as complaints about the distant site licensed independent Physician, Dentist or Practitioner from patients, licensed independent Physician, Dentist or Practitioners, or staff at the hospital.

Verification of privileges from facilities at which the applicant holds telemedicine privileges will be performed. If the applicant holds telemedicine privileges at more than ten (10) facilities within the United States, a random representative sample of at least five (5), including the most recent three (3), facilities will be chosen for affiliation verifications and demonstrated competence. Other verifications/documentation to be obtained and/or maintained include:

(a) CV (Curriculum Vitae)
(b) Current Photo
(c) Copy of Current Driver’s License
(d) Current unrestricted and valid license in the State of Indiana
(e) Federal DEA
(f) Indiana CSR
(g) Malpractice insurance with coverage limits consistent with Board requirements
(h) National Practitioner Databank
(i) Delineation of Privilege form for Community Hospitals
(j) Letter of verification from the distant site that includes initial appointment date, staff status/category, Board approved privileges, reappointment dates and current standing with the Medical Staff.

The Physician, Dentist or Practitioner must concurrently maintain privileges, at a minimum, for the same scope of services at the distant-site hospital as he/she is requesting at the originating-site hospital.

The approval processes for Telemedicine Staff privileges shall be the same person as outlined in the Initial Application section and Renewal of Privileges sections of the Credentials Procedures.

Physician, Dentist or Practitioners requesting Telemedicine Staff privileges shall be eligible for Temporary Privileges via the process outlined in the Temporary Privileges section of the Credentials Procedures.

**SECTION 3.8. DENTAL ANDPODIATRY PRIVILEGES.** The scope and extent of surgical procedures that a dentist or podiatrist may perform shall be specifically delineated. All such surgical procedures shall be performed under the overall responsibility of the Surgery Clinical Service Chair. A physician member of the Staff shall be responsible for the care of any medical problems of a dental or podiatry patient that may be present or arise during hospitalization.

**ARTICLE IV. CREDENTIALING**
SECTION 4.1. APPOINTMENT AND REAPPOINTMENT OF MEDICAL STAFF MEMBERS. The following steps describe the process for credentialing (appointment and reappointment) of Medical Staff Members. Associated details may be found in the Medical Staff Rules and Regulations.

4.1.1. Individuals interested in appointment to the Medical Staff may request from the Hospital an application and a list of the eligibility requirements for membership. Eligible Members will automatically be sent an application for reappointment in a timely fashion.

4.1.2. Upon completion and submission of the application to the medical staff office, a designated individual will verify the contents and confirm that the applicant is eligible to have the application processed further. If the application shows the applicant is not eligible for membership, he will be notified. No action will occur regarding the application.

4.1.3. A completed and verified application will be forwarded by the Medical Staff Office to the appropriate Clinical Service Chair (or designee) for review and evaluation. This review will include consideration of the applicant’s individual character, individual clinical competence, individual training, individual experience, and individual professional judgment and conduct. The Clinical Service Chair will forward a recommendation concerning appointment of the applicant to the Credentials Committee.

4.1.4. The Credentials Committee will review the application and forward its recommendation to the Medical Executive Committee (MEC).

4.1.5. The MEC will review the recommendation and forward its recommendation to the Board regarding membership, and if appropriate, staff category, and clinical service assignment. The MEC may refer an application back to the Credentials Committee if it feels more information or evaluation of the applicant is necessary.

4.1.6. The Board will review the recommendation and determine whether to offer the applicant membership and whether any restrictions or conditions should be attached to an offer of membership or clinical Privileges. Membership will be granted upon approval of the Board.

4.1.7. Applicants may request a hearing before an adverse recommendation of the MEC is forwarded to the Board for action. Applicants may request a hearing if a favorable recommendation of the MEC is rejected or adversely affected by the Board in accordance with Volume II.

SECTION 4.2 GRANTING OF CLINICAL PRIVILEGES. The following steps describe the process for granting clinical Privileges to qualified Members and Practitioners. Associated details may be found in Medical Staff Rules and Regulations and on Medical Staff Delineation of Privileges documents. Members and Practitioners shall be entitled to exercise only those Privileges specifically granted to them by the Board. The Medical Staff may recommend clinical Privileges for Practitioners who are not Members of the Medical Staff but who hold a license in the State of Indiana to practice independently.

4.2.1. Physicians and Dentists initially applying for Medical Staff membership or for reappointment must complete the appropriate forms to request specific Privileges. Practitioners ineligible for Medical Staff membership but eligible for Privileges will complete the appropriate request forms. These forms are available from the Hospital Medical Staff Office.

4.2.2. Upon completion and submission of the appropriate forms to the Medical Staff Office, a designated individual will confirm that the applicant is eligible to have the request processed further. Privilege requests that do not demonstrate compliance with eligibility requirements will not be processed further.

4.2.3. Completed Privilege request forms will be forwarded by the Medical Staff Office to the appropriate Clinical Service Chair (or designee) for review and evaluation. This review will include consideration of the Physician’s,
Dentist’s or Practitioners individual character, individual clinical competence, individual training, individual experience, and individual professional judgment and conduct.

4.2.4. The Clinical Service Chair will forward a recommendation to the Medical Staff Credentials Committee.

4.2.5. The Credentials Committee will review the applicant’s requests and the input of the Clinical Service Chair and recommend a specific action to the MEC.

4.2.6. The MEC will review the privileging requests and recommend specific actions on them to the Board.

4.2.7. The Board will review the privileging request and either reject the requests, modify them, or grant the Privileges being sought.

4.2.8. Applicants may request a hearing before an adverse recommendation of the MEC is forwarded to the Board for approval. Applicants may request a hearing if a favorable recommendation of the MEC is rejected or adversely affected by the Board. This is the same hearing and appeal rights afforded to Members in accordance with Volume II. This hearing process is set out in the policy.

SECTION 4.3. GENERAL PROCEDURE. The Medical Staff through designated Clinical Services, committees, and officers shall evaluate and consider each application for appointment for reappointment and clinical Privileges and each request for modification of staff membership or Privileges and shall adopt and transmit recommendations to the Board.

SECTION 4.4. APPLICATION FOR INITIAL APPLICATION

4.4.1. APPLICATION FORM. Each application for appointment to the Medical Staff shall be submitted in writing or electronically submitted on the prescribed form issued by the Hospital with manual or approved electronic signature by the applicant. Any qualified Physician or Dentist who wishes to apply for membership on the Medical staff shall contact the Hospital to request an application. Upon receipt of initial completed application the Hospital shall make available through the Hospital intranet the Medical Staff Bylaws and Medical Staff procedures, selected associated policies and procedures of the Medical Staff, a Delineation of Privileges request form, and other specific Hospital required documents.

4.4.2. CONTENT OF APPLICATION FORM. The application for appointment shall be in a form determined by the Hospital in consultation with the Medical Staff Credentials Committee and MEC. The completed application and its attachments shall include, but are not limited to, the following information:

4.4.3. ACKNOWLEDGEMENT AND AGREEMENT. A statement signed by the applicant to the effect that he/she has read and agrees to be bound by the Bylaws and any Medical Staff policies or procedures that are provided to the applicant as part of the applicant process. The applicant also agrees to be bound by these documents in all matters relating to consideration of the application whether or not the physician is granted membership and/or clinical Privileges. Furthermore, the applicant agrees that if he/she is granted Medical Staff membership and/or Privileges, he/she agrees to follow and be bound by any and all Medical Staff, Hospital, and Hospital policies and meet all responsibilities of Medical Staff membership.

4.4.4. QUALIFICATIONS. Detailed information concerning the applicant’s qualifications, including information in order to satisfy the Basic Eligibility and Qualifications of Medical Staff Membership (Article II of the Bylaws) and any additional qualifications necessary to be granted any Privileges requested.

4.4.5. REQUESTS. Specific requests stating the Clinical Service and the Privileges for which the applicant wishes to be considered. The applicant shall be eligible to request only those privileges for a service the Board has approved the Hospital to perform.
4.4.6. Peer Reference. The names of at least two (2) practitioners who have worked with applicant and observed the applicant’s professional performance and who can provide references as to the applicant’s professional ability and judgement, ethical character, and ability to work cooperatively with other Physicians, Dentists or Practitioners and Hospital personnel, such that patients treated by the applicant receive quality care delivered in a professional and efficient manner. Information provided by the reference should be address the applicant’s abilities with regard to the general competencies adopted from time to time by the Accreditation Council for Graduate Medical Education (ACGME). In general, peer references should be submitted on a peer reference form provided by the Hospital and/or the reference should answer specific questions posed on this form.

4.4.7. Ethical Pledges. A pledge signed by the applicant agreeing to provide professional services in an ethical manner and to adhere to generally recognized professional ethics and the Medical Staff Code of Conduct Policy.

4.4.8. Professional Sanctions. Information as to whether the applicant’s membership status and/or Medical Staff Privileges have ever been voluntary or involuntarily revoked, suspended, reduced, subjected to restrictions or limitation not applicable to all other Members in the same Medical Staff category, or not renewed at any other Hospital or health care institution, and as to whether any of the following has ever been voluntary or involuntarily suspended, revoked, or denied:

i. Staff membership status or clinical Privileges at any other Hospital or health care institutions;
ii. Specialty board certification;
iii. Licensure to practice any profession in any jurisdiction;
iv. Drug Enforcement (DEA) number or a state controlled substance licensure; or
v. Information as to any current or pending sanctions, affecting participation in any Federal Healthcare Program or any actions which cause the Physician, Dentist or Practitioner to become ineligible for such programs.

If any such actions were ever taken or if any such actions are currently pending, the particulars of these actions shall be included.

4.4.9. Criminal Proceedings. Information as to whether the applicant has ever been named as a defendant in any criminal proceedings, regardless of outcome

4.4.10 Felony Convictions. Information as to whether the applicant has ever been convicted of a felony or submitted a plea of guilty or no contest, if a felony prosecution is now pending against the applicant, and the particulars of any such conviction, settlement or prosecution, if any.

4.4.11. History of Medical Staff Membership. A chronological history listing all of applicant’s past Medical Staff Memberships and associated Privileges, including the full addresses of the facilities at which such memberships of Privileges were held.


4.4.13. Education and Training History. A chronological history of the applicant’s medical education and training undergraduate education, all graduate education in the health care field, and all post-graduate training (internship/residencies) in a health care field.

4.4.14. Notification of Release and Immunity Statement. Such releases, waivers, and authorizations as are presented to the applicant by the Hospital. These will include a statement signed by the applicant authorizing and consenting to allow Medical Staff and Hospital representatives to provide other Hospitals, medical associations, licensing boards, and other organizations concerned with provider performance
and the quality and efficiency of patient care with any relevant information the Hospital or Medical Staff may have concerning the applicant. This statement will also release from liability the Hospital, its Medical staff, and their representatives for sharing with appropriate health care and licensing entities information concerning the professional competence, ethics, and other qualifications of the applicant for staff appointment and Privileges, including information otherwise privileged or confidential, to the full extent permitted by Indiana law. The applicant promises not to sue or to hold harmless all individuals who either provide information from or to the Hospital pertaining to the evaluation of the application, reapplication or privileges being requested.

4.4.15. PROFESSIONAL LIABILITY ACTIONS. Particulars regarding medical malpractice claims filed against the applicant, any adverse and/or pending malpractice decisions or settlements, and information concerning any cancellation, non-renewal, or limitation of malpractice insurance coverage.

4.4.16. MISCELLANEOUS INFORMATION. Such other information relating to evaluation of applicant’s professional qualifications, ethical character and professional conduct, current competence, and prior professional experience, including utilization of Hospital Resources as may be deemed relevant by the EC and the Hospital Board.

4.4.17. MINIMUM BASIC CRITERIA. The following basic criteria must be appropriately documented and the information reasonably confirmed:

(a) EVIDENCE OF CURRENT LICENSURE/REGISTRATIONS. (Unrestricted Indiana State License, Unrestricted Federal DEA, CSR as appropriate to specialty.) Licensure is verified with the primary source, copies of such licenses or registrations are not necessary.
(b) RELEVANT TRAINING AND/OR EXPERIENCE. At the time of appointment and initial granting of clinical Privileges Hospital may require verification of relevant training or experience from the primary source(s), when feasible.
(c) CURRENT COMPETENCE:
   i. Recent letters of verification from the applicant’s residency program director or designee if residency training was within five years of initial application. Confirmation of board certification or qualification for certification from the appropriate specialty board. A physician applicant, MD or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and be currently board certified or become board certified within five (5) years of eligibility as defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association, except as otherwise decided by the MEC.
   ii. All new applicants to the Medical Staff as of June 1, 2011 must, in their primary specialty, recertify and maintain current board certification as defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association, except as otherwise determined by the MEC.
   iii. Written documentation from two (2) individual personally acquainted first hand with the applicant’s recent professional and clinical performance as described in paragraph 2.3.2 (d) above.
   iv. Ability to Perform Privileges Requested (Health Status). A health status statement, contained in the application, and signed by the applicant indicating that no physical or mental health problems exist that could affect his/her practice, Medical Staff membership and the privileges granted by the Board.

4.4.18 PROFESSIONAL LIABILITY INSURANCE. Possess current, valid professional liability insurance that covers all privileges requested with an insurance carrier authorized by the State of Indiana Department of Insurance as a licensed provider of professional malpractice insurance. Insurance must be carried in a form and amount as determined from time to time by the Board;
4.4.19. **ACCESSIBILITY.** Have a practice or residence close enough to the Hospital to provide timely and continuous care for their patients as determined by the Board;

4.4.20. **FEDERAL PROGRAM PARTICIPATION.** Be eligible to participate in Medicare, Medicaid, and other federally sponsored health programs;

4.4.21. **COLLEGIALITY.** Be able to demonstrate the ability to work cooperatively with others and to treat others within the Hospital with respect at all times. Evidence of ability to display appropriate conduct and behavior shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations.

**SECTION 4.5. APPLICATION FEE.** A non-refundable fee, in an amount established by the MEC and ratified by the Board, shall be received from the applicant at the time of application for appointment or reappointment. Applications submitted without any accompanying fee will not be accepted for processing.

**SECTION 4.6. EFFECT OF APPLICATION.** By applying for appointment to the Medical Staff, the application:

4.6.1. Agrees to provide any and all information to complete the application and to resolve any questions relating to his/her application that are requested or posed by Medical Staff, Hospital, or Board representatives. A completed application must be signed and dated and must include: a current picture ID card issued by a state or federal agency; copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency; a completed privilege delineation form; completed reference forms from peers knowledgeable about the applicant’s competence to perform the privileges being requested; practitioner specific quality and clinical outcome data if available; all applicable fees.

4.6.2. Agrees to appear for interview(s) upon request.

4.6.3. Authorizes Hospital representatives to consult with other hospitals and medical staffs who have been associated with the applicant with anyone who may have information bearing on the applicant’s clinical competence and qualifications for Medical Staff membership or Privileges.

4.6.4. Consents to the inspection by Hospital representatives of all records and documents that may be material to an evaluation of physician’s professional and ethical qualifications for staff membership.

4.6.5. Agrees that in the event of any adverse recommendations or decisions with respect to staff membership or Privileges, as defined in these Bylaws, the applicant shall exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action.

4.6.6. Releases from liability all individuals and organizations that provide information, including otherwise legally privileged or confidential information to Hospital representatives concerning the applicant’s competence, professional ethics, character, physical and mental health, professional conduct, and other qualifications for staff appointment and clinical Privileges.

4.6.7. Signifies that information submitted in his or her application is true to the best of his/her knowledge and belief and that he/she understands that any significant misstatement(s) on or omission(s) from his/her application shall constitute ground for rejection of the application and application will not be further processed.

4.6.8. Any misstatement or intentional omission from an application from appointment or reappointment, the Hospital may stop processing the application (or if appointment has been granted prior to the discovery of a misstatement or omission), appointment and privileges may be deemed to be automatically relinquished. In either situation, there shall be no entitlement to hearing or appeal.

4.6.9. Agrees to provide to the Medical Staff Office, any and all requested information needed to process the application within 45 days of request or the application will be considered to be voluntarily withdrawn.
SECTION 4.7. PROCESSING OF INITIAL APPLICATIONS

4.7.1. APPLICANT’S BURDEN. The application shall have the burden of producing adequate information for a proper evaluation of the physician's experience, background, training, professional conduct, clinical competence, and ability to adequately perform the Privileges requested, and of resolving any doubts about these or any of the other qualifications specified in the Medical Staff Bylaws or in associated Medical Staff procedures. The applicant must be able to demonstrate to the satisfaction of the MEC and Board proficiency in the following six general competencies as described by the Accreditation Council of Graduate Medical Education (ACGME): patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

4.7.2. APPLICANT INTERVIEW. All applicants for appointment to the Medical Staff and/or clinical Privileges may be required to participate in an interview at the discretion of the Clinical Service Chair, Medical Staff Credentials Committee, MEC, or Board. The interview may take place in person or by telephone, video or computer link at the discretion of the party calling for interview. The interview will be used to gather information about the applicant, to ask clinical questions pertaining to the privileges being requested and to communicate information to the applicant concerning Medical Staff responsibilities and expectations.

4.7.3. VERIFICATION OF INFORMATION. The applicant shall deliver a completed application to the Medical Staff Office which shall in a timely fashion, seek to collect or verify the references, licensure, and other qualifications evidence submitted. Hospital shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information and provide it to the Hospital in a timely manner. Once collection and verification is completed, the Hospital shall forward a complete verified application and it's supporting materials to the Clinical Service Chair to which the applicant will be assigned if granted staff membership.

If the requirements of this Article II are not met, the applicant will be notified that he/she is ineligible to apply for membership or privileges. The applicant will not be processed and no right to due process or to a hearing will be triggered.

4.7.4. CLINICAL SERVICE CHAIR REVIEW. The relevant Clinical Service Chair, or designee, shall review the completed and verified application and supporting documentation for completeness and for the purposes of determining the character, professional competence, qualifications, and ethical standing of the applicant to fulfill the requirements of Staff membership and/or the Privileges requested.

The Clinical Service Chair may conduct an interview with applicant and shall utilize appropriate sources of information, request additional information from the applicant or elsewhere as needed, and evaluation applicant references, to determine whether the applicant satisfies the criteria set forth in the Bylaws relating to membership on the Medical Staff, and to determine whether the applicant possess those professional and ethical qualities necessary to the provision of quality medical care. The Clinical Service Chair shall transmit a report to the Medical Staff Credentials Committee and MEC with recommendations as to the Medical Staff appointment, Staff category, Clinical Service affiliation, clinical Privileges to be granted, and any special conditions to be attached to the appointment. A Clinical Service Chair may also indicate that the Credentials Committee defers action on the application. The reason for each recommendation shall be and supported by reference to the completed application and all other documentation considered by a Chair, all of which shall be transmitted with the report.

4.7.5. CREDENTIALS COMMITTEE ACTION. Once the Clinical Service Chair has made a report on an application, the verified application and its supporting materials shall be forwarded by the Medical Staff Office to the Medical Staff Credentials Committee. This committee shall review the application, supporting documentation, the Clinical Service Chair’s report; and such other information available to it that may be relevant to consideration of the applicant’s qualifications and it may conduct a personal interview.
After its review of the applicant’s credentials, the Credentials Committee shall submit a recommendation to the MEC and Quality of Care Committee. This recommendation shall address the applicant’s Medical Staff membership and category, Clinical Service affiliation, Privileges, and any specific conditions relating to appointment and/or Privileges. Minority views regarding any or all recommendations of the Credentials Committee may be also included.

4.7.6. MEDICAL EXECUTIVE COMMITTEE ACTION. At its next meeting after receipt of the Clinical Service Chair report and the Medical Staff Credentials Committee recommendation, the MEC shall review the applicant’s request for membership and/or Privileges. The MEC may utilize appropriate additional sources of information, including personal interviews with the applicant, as it deems necessary to complete its evaluation.

After completing its review of the applicant’s qualification the MEC shall transmit to the Board a recommendation regarding appointment and/or Privileges for the applicant, including whether the applicant’s requests should be accepted, accepted with modifications or qualifications, or rejected. Where appointment is recommended, the MEC shall also recommend Staff category and Clinical Service affiliation. Where the MEC recommends that the applicant’s requests for membership and/or Privileges be rejected, modified qualified, or otherwise restricted, the report of the MEC shall set forth reasons for such recommendation(s).

If an MEC recommendation is not unanimous, a minority report may be submitted to the Board.

4.7.7. EFFECT OF MEDICAL EXECUTIVE COMMITTEE (MEC) ACTION.

(a) FAVORABLE RECOMMENDATION. When the recommendation of the MEC is favorable to the applicant, the recommendation together with supporting documentation shall be forwarded to the Board.

(b) DEFERRED. Any action by the MEC to defer a recommendation on the application in order to carry out further evaluation must be followed up within sixty (60) days with a recommendation to the Board.

4.7.8. ADVERSE EXECUTIVE COMMITTEE RECOMMENDATION. When the MEC recommends denial or a restriction of membership or a requested privilege based on a determination of unprofessional conduct or inadequate clinical competence, the Medical Staff President or CEO shall inform the Physicians, Dentist or Practitioner by Special Notice (as defined in Volume I of the Bylaws) within ten (10) days.

4.7.9. APPLICANTS FOR CONSIDERATION BY THE BOARD. At its next meeting after receipt of the reports and recommendations of the MEC regarding an initial application for membership and/or Privileges, the Board shall consider and act on such recommendations provided the member has been provided an opportunity for a hearing or appeal if the MEC makes an adverse determination. If the Board decided to defer action on the application pending further consideration by the MEC, or if the Board does not accept the recommendation of the MEC, it may refer the application back to the MEC for further consideration, subject to the requirement that a final recommendation be provided to the Board by the MEC within sixty (60) days. At the meeting next following the receipt of the second report of the MEC, the Hospital Board shall render its final decision regarding the application.

If the Board accepts a favorable MEC recommendation it shall act to grant the requested membership and/or Privileges. The Boards’ decision and the notice of appointment shall include:

(a) The Staff category to which the applicant is appointed;
(b) The Clinical Service to which he/she is assigned;
(c) The Privileges he/she may exercise; and
(d) Any special conditions attached to the appointment or exercise of Privileges
4.7.10. If the Board’s action is adverse to the applicant, a Special Notice, (as defined in Volume I of the Bylaws) stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these Bylaws.

4.7.11. BOARD CONSIDERATION OF EXPEDITED APPLICATIONS. A Board Executive Committee, composed of at least two (2) members of the Board may conduct an expedited credentials review when applicants present application that raise no clear concerns. In particular, the following criteria must be met in order to complete an expedited credentials review:

(a) Applicant submits a completed application;
(b) MEC makes a final positive recommendation and without limitation(s);
(c) There are no current challenges or previously successful challenges to the applicant’s licensure or registration;
(d) Applicant has never received an involuntary termination of Medical Staff membership at another organization;
(e) Applicant has never received involuntary limitation, reduction, denial, or loss of Clinical Privileges; or
(f) There has never been an adverse final judgment to the applicant in a professional liability action.

This list is not exhaustive and the Hospital Board or the Board Executive Committee shall have the discretion to determine whether or not an application qualified for expedited review.

After reviewing the recommendations of the MEC, a positive decision by the Executive Committee of the Board shall result in the status and/or Privileges requested. If the decision by the Executive Committee of the Board is adverse the matter will be referred to the full Board for further evaluation at its next regularly scheduled meeting.

The full Board shall consider and ratify all positive Executive Committee decisions at its next regularly scheduled meeting. If the Board does not ratify the positive recommendation of its Executive Committee, the application will be handled as in the same manner as an application that has not received expedited review.

4.7.12. CONFLICT RESOLUTION. Whenever the Board’s proposed decision will be contrary to the MEC’s recommendation, the Board shall submit the matter to a Joint Conference as provided in Sections 11.3 and 11.4 of Volume I of these Medical Staff Bylaws. This Joint Conference will be held as soon as practicable and the Board will postpone any final determination on an applicant until such conference is held.

4.7.13. NOTICE OF FINAL DECISION. Notice of the final action of the Hospital Board on an applicant shall be given to the Hospital CEO who will communicate the Board’s decision to the applicant regarding membership and/or Privileges and provide Special Notice (as defined in Volume I of the Bylaws) of any adverse action (as described in Section 7.1 “Grounds for Hearing” of Volume II of the Bylaws) on the application in a timely manner.

The Hospital Board shall give Notice (as defined in Volume I of the Bylaws) of its final decision through the Hospital CEO to the Medical Staff President, the MEC, and the appropriate Clinical Service Chair.

4.7.14. TIME PERIODS FOR PROCESSING. Applications for Medical Staff appointment and/or Privileges shall be considered in a timely and good faith manner by all individuals and groups required by Medical Staff Bylaws and policies to act upon them and shall be processed whenever possible within the time periods specified in this section. Any incomplete application after six (6) months shall be considered voluntarily withdrawn.

Within forty-five (45) days after receipt by the Clinical Service Chair of a completed application for membership and/or clinical Privileges, the Clinical Service Chair report shall be submitted to Medical Staff Credentials Committee.

Within forty-five (45) days after the receipt of the Clinical Service Chair’s report, the Medical Staff Credentials Committee through its Chair shall submit a written recommendation to the Medical Executive Committee.
Within forty-five (45) days after receipt of recommendations from the Medical Staff Credentials Committee or its Chair, the MEC shall submit a recommendation regarding appointment and/or Privileges to the Hospital Board.

The Board will act on recommendations from the MEC at its next regularly scheduled meeting that shall occur within ninety (90) days.

The time periods in this section are guidelines and deviations will not entitle the application to any procedural due process rights.

SECTION 4.8. REAPPOINTMENT PROCESS.

4.8.1. APPLICATION FOR REAPPOINTMENT. Reappointment will be for a period of up to two (2) two years and, effective January 1, 2012 shall be based on the birth date of the applicant. At least one hundred twenty (120) days prior to the expiration date of the physician’s current appointment of membership and/or Privileges, the Hospital shall provide each Member or Practitioner with an updated application form for reappointment and any required Hospital specific forms and documents for completion which must be received prior to the reappointment application being acted upon. Each Member or Practitioner who desires reappointment shall, at least 45 days prior to such expiration date, complete such forms and return them to the Medical Staff Office. Failure to return the completed form(s) prior to such expiration date may, at the discretion of the Medical Staff Office, be considered a voluntary resignation of membership and clinical Privileges effective at the end of the Staff member’s current term.

4.8.2. CONTENT OF APPLICATION. The applicant for reappointment shall be in a prescribed form setting forth, without limitation, the following information:

(a) Specific requests setting forth the category of Staff membership to which the applicant seeks to be reappointed, the Clinical Service to which the applicant seeks membership, and the privileges for which the applicant wishes to be considered.

(b) Continuing training, education, and experience (including the activity log) that qualify the Staff member for the Privileges sought on reappointment. Continuing education must relate, at least in part, to the Privileges requested and is provided to the Hospital upon request.

(c) A statement that no health problems exist that could affect the applicant’s ability to perform the Privileges requested.

(d) The name and address of any other health care organization or practice setting where the Staff member provided professional services during the preceding appointment period.

(e) Current, unrestricted State License, Drug Enforcement (DEA), and State Board of Pharmacy registration, as applicable.

(f) Information as to whether the applicant’s membership status and/or Medical Staff Privileges have ever been voluntary or involuntarily revoked, suspended, reduced, subjected to restrictions or limitation if not applicable to all other Members in the same Medical Staff category, or not renewed at any other hospital or health care institution, and as to whether any of the following has ever been voluntary or involuntarily suspended, revoked, or denied:
   i. Staff membership status or clinical Privileges at any other Hospital or health care institutions;
   ii. Initial specialty board certifications;
   iii. Licensure to practice any profession in any jurisdiction; or
   iv. Drug Enforcement (DEA) and CSR number;
   v. National Practitioner Data Bank (NPDB) information which will also be checked during reappointment/renewal of privileges and whenever new privileges are requested.

If any such actions were ever taken or if any such actions are now pending, the particulars thereof shall be included.
(g) Information as to whether the applicant has ever been prosecuted for, convicted of or pled no contest to a felony and, if so, the particulars of any such convictions.

(h) Information as to whether the applicant has ever been named as a defendant in any criminal proceedings, regardless of the outcome.

(i) Evidence of continuous malpractice insurance coverage in an amount that may be determined from time to time by action of the Board,

(j) A list of all malpractice complaints filed against the Physician Dentist or Practitioner and the particulars regarding any adverse malpractice decisions or settlements.

(k) Such other specific information about the Staff member’s professional ethics, qualifications, and ability that may bear on his/her ability to provide medical or surgical care in the Hospital.

4.8.3. COMPLETION AND VERIFICATION OF INFORMATION. The information provided on each application for reappointment and all other supporting materials and documentation, including information regarding the Staff member’s professional activities, performance and conduct in the Hospital and query reports from the National Practitioners Data Bank (NPDB) shall be collected and verified. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her qualifications and of resolving and questions regarding such qualification. When collection and verification has been completed and the Hospital has determined that the application is complete, it shall transmit the application and all supporting material to the Clinical Service Chair to which the applicant is assigned.

4.8.4. CLINICAL SERVICE CHAIR REVIEW. The Clinical Service Chair or designee shall review the application for reappointment and all other pertinent information, including the application and all supporting documentation. Such review shall consist of an appraisal of the following factors, without limitation:

(l) Professional performance, including applicant’s patterns of practice in the performance improvement program, data from ongoing professional practice evaluation, utilization review, infection control activities, blood utilization, operative and invasive procedure review, medical records review, and pharmacy and therapeutic review, as appropriate.

(m) The Privileges currently exercised by the applicant and the basis for any requested modifications.

(n) Applicant’s health status, where relevant to ensure the safe practice of the privileges requested.

(o) Attestation by the applicant that they have completed seventy (70) hours of Category I CME every two (2) years.

(p) Applicant’s service on Medical Staff and Hospital committees.

(q) Applicant’s record relating to timely completion of medical records

(r) Applicant’s demonstrated ability to work cooperatively with other Physicians, Dentists or Practitioners and Hospital personnel, to comply with policies on professional conduct, and to avoid unprofessional conduct in the Hospital that may have a disruptive effect on patient care or impede the efficient and safe operation of the Hospital.

(s) Applicant’s record of compliance with the Medical Staff Bylaws, Rules, Regulations and Policies of the Medical Staff and with Hospital policies applicable to Medical Staff Members or Practitioners granted Privileges.

4.8.5. REPORT OF THE CLINICAL SERVICE CHAIR. The Clinical Service Chair shall review the application and information in the Member’s file and shall submit a report to the Credentials Committee regarding the reappointment of and/or Privileges to be exercised by such member. The Clinical Service Chair report shall contain the following, without limitation:

(t) Support for reappointment or denial of reappointment, including any suggested restrictions or conditions on reappointment

(u) Report for Clinical Service affiliation and Staff category.

(v) The Privileges to be granted, including any restrictions on such Privileges.
4.8.6. MEDICAL STAFF CREDENTIALS COMMITTEE ACTION. The Medical Staff Credentials Committee shall review each application and all relevant information available to it, including the Clinical Service Chair’s signature indicating that they have reviewed the application. The Credentials Committee shall make a recommendation to the MEC on the application for reappointment. The recommendation of Credentials Committee shall comment on, as appropriate, the same specific types of information contained in the section 2.7.5 above. Upon the request of the MEC, the recommendation of the Credentials Committee shall be accompanied, as appropriate, by all relevant documentation including the application, supporting information, and the Clinical Service Chair Report.

4.8.7. MEDICAL EXECUTIVE COMMITTEE ACTION. The MEC shall review each application for reappointment and all other relevant information available to it. The MEC may choose to interview the applicant prior to rendering a recommendation. The MEC shall make a recommendation to the Board regarding the application for reappointment. The recommendation of the MEC shall contain, as appropriate, the same specific types of recommendations contained in the report of the Credentials Committee. Upon the request of the Board, the recommendation of the MEC shall be accompanied by all relevant documentation, including the application, supporting information, and the report of the Credentials Committee.

4.8.8. FINAL PROCESSING AND BOARD ACTION. Following the recommendation of the Medical Executive Committee (MEC) to the Board, the procedure provided in the Credentials Procedures relating to initial applications shall be followed and the Board shall render a decision prior to the expiration date of the applicant’s appointment. Where the Board disagrees with the recommendation of the MEC, the matter will be brought to a Joint Conference as described in Sections 11.3 and 11.4 in Volume I of these Bylaws.

4.8.9. BASIS FOR RECOMMENDATION. Each recommendation concerning the reappointment of a Member’s membership and/or Privileges shall be based upon review not only of those matters set forth in the Medical Staff Bylaws and policies pertaining to such Member, but also on any other information bearing on the ability and willingness of the Member to contribute to the rendering of quality health care within the Hospital and to contribute to the mission of the Hospital.

4.8.10. NOTICE OF FINAL DECISION. Notice of the final action of the Hospital Board on a reappointment shall be given to the Hospital CEO who will communicate the Board’s decision to the applicant regarding membership and/or Privileges and provide Special Notice (as defined in Volume I of the Bylaws) of any adverse action (as described in Section 7.1 “Grounds for Hearing” of Volume II of the Bylaws) on the application in a timely manner.

SECTION 4.9. REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS AND/OR PRIVILEGES. A Medical Staff member may, either in connection with reappointment or at any other time request modification of his/her staff category, clinical service affiliation or clinical Privileges by submitting a written application to the Medical Staff Office in such form as may be prescribed by the MEC and the Board. Such Staff member shall have the burden of justifying such modification(s). Such application shall be processed in substantially the same manner as applications for reappointment to Medical Staff membership, except that the pertinent time limits shall be those applicable to appointments to Medical Staff membership, as provided in this Credentials Procedures.

SECTION 4.10. EFFECTIVE DATE OF REAPPOINTMENT/MODIFICATIONS OF APPOINTMENTS AND/OR STAFF PRIVILEGES. Reappointments approved by the Board, including Privileges awarded in connection with such reappointments, modification of categories of Staff membership or Clinical Service affiliation, and/or Privileges, shall take effect on the date such modification are approved by the Quality of Care Committee of the Board.
ARTICLE V.
OFFICERS AND IMMEDIATE PAST PRESIDENT OF THE MEDICAL STAFF

SECTION 5.1. OFFICERS OF THE MEDICAL STAFF. The Officers of the Medical Staff shall be:
President
President-Elect
Treasurer & Communications Officer

SECTION 5.2. QUALIFICATIONS. To be eligible for office, the following criteria at the time of nomination and continually throughout the term of office must be satisfied. The member must be qualified as described below:

(a) Active Staff;
(b) Board Certified by a specialty board recognized by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) or found to have comparable competency by actions of the Credentials Committee and MEC;
(c) Not the subject of a pending adverse recommendation before the Board
(d) Constructively participated in Medical Staff activities, such as, but not limited to activities such as performance improvement/peer review and credentialing/privileging;
(e) Willing and have the ability to devote the necessary time to discharge faithfully the duties and responsibilities of the office;
(f) Experienced in leadership position, or involvement in performance improvement functions for at least two (2) years;
(g) Willing to attend continuing education programs relating to Medical Staff leadership and/or peer review and credentialing functions prior to or during the term of office;
(h) In compliance with any and all policies of the Medical Staff and Hospital including Conflicts of interest;
(i) Must have demonstrated an ability to work well with and communicate well with others.

SECTION 5.3. SELECTION. The Leadership Selection Committee shall select nominees for placement on the election ballot of officers using the following process. The Leadership Selection Committee is made up of the Immediate Past President of the Medical Staff, who shall serve as the chairperson. The MEC shall appoint one other member of the EC and ratify three (3) additional Members recommended by the General Medical staff who will serve as voting Members of the Leadership Selection Committee.

(a) The Leadership Selection Committee will meet at least ninety (90) days prior to the General Staff Meeting at which the election will be held.
(b) The Leadership Selection Committee will assure that at least one name is placed on the ballot for election, as appropriate, to each Medical Staff Officer and MEC at-large position.
(c) The Leadership Selection Committee shall electronically notify and formally post on the Medical Staff intranet, its list of nominees to the Active Members of the Medical Staff at least sixty (60) days prior to the annual meeting
(d) In order for a nominee to be placed on the ballot the following criteria must be met:
   i. Candidates must meet the qualifications set forth in Section 4.2. The Leadership Selection Committee will have discretion to determine if these criteria have been met.
   ii. Candidates must be approved by the Leadership Selection Committee for placement on the ballot and candidates must agree to be placed on the ballot.
   iii. A petition signed by at least ten percent (10%) of the Members of the Active Staff may also make nominations for Officers and MEC at-large Members. Such petition must be submitted to the President of the Medical Staff at least forty-five (45) days prior to the election for placement on the ballot. The candidate nominated by petition must be confirmed by the Leadership Selection Committee to meet the qualifications in Section 4.2 above before he/she can be placed on the ballot.
SECTION 5.4. ELECTION.

(a) Officers of the Medical Staff and MEC at-large Members shall be elected using a ballot which may be distributed to eligible voting Members of the Medical Staff at a general Medical Staff meeting, by mail or electronically. The mechanics of distributing ballots and counting votes will be determined by the MEC. The individual who receives the greatest number of votes from Active Medical Staff Members who received ballots and voted shall be elected to that office. Voting by proxy is not permitted.

(b) Officers and MEC at-large Members shall be eligible to assume office once the Board has ratified their election. Such ratification cannot be unreasonably withheld.

(c) Elections for Officers and MEC at-large Members will take place in the fourth quarter of each year, generally in December, consistent with the procedures approved by the MEC.

SECTION 5.5. TERM. All Officers and MEC at-large Members shall serve a term of two (2) years from the first day of March following their election, or until their successors are elected. All officers and MEC at-large Members may be re-elected. The Immediate Past President of the Medical Staff will serve until the current President of the Medical Staff completes a term and steps down from that office.

SECTION 5.6. DUTIES OF ELECTED OFFICERS AND THE IMMEDIATE PAST PRESIDENT.

(a) **PRESIDENT:** The President shall serve as the chief administrative officer and principal elected official on the Medical Staff.

(b) **PRESIDENT-ELECT:** The President-Elect shall be a member of the MEC and shall be required to assist the President of the Medical Staff and to perform such duties as may be assigned to him by the President of the Medical Staff. The President-Elect will Chair the Medial Staff Quality Council of the MEC. In the absence of the President of the Medical Staff or upon the occurrence of a vacancy in the office of President of the Medical Staff, the President-Elect of the Medical Staff shall assume the responsibilities, exercise the authority, and perform the duties assigned to the President of the Medical Staff until the President of the Medical staff returns or that office is filled.

(c) **TREASURER & COMMUNICATIONS OFFICER OF THE MEDICAL STAFF.** The Treasurer and Communications Officer will collaborate with the Medical Staff Office and Clinical Service Chair to assure the timely and accurate recording, distribution and confidentiality of medical staff minutes, reports and correspondence. This officer oversees the medical staff treasurer, including the notification, collection and accounting of medical staff dues, fees and fines that may be set by the MEC.

(d) **IMMEDIATE PAST PRIENDENT:** The Immediate Past President may attend MEC meetings when invited by the President of the Medical Staff. They shall serve as an advisor to the President of the Medical Staff. They may attend the Medical Staff Credentials Committee upon invitation of the Credentials Committee Chair. The Immediate Past President shall chair the Leadership Selection Committee, provide performance feedback to the President and the President-Elect on an annual basis and perform other functions delegated to him by the President of the Medical Staff.

SECTION 5.7. REMOVAL FOR CAUSE.

(a) **FOR CAUSE REMOVAL.** Officers and MEC at-large Members of the Medical Staff may be removed by an affirmative vote of two-thirds of the Active Medical Staff president at any general or special meeting, subject to approval of the Board, in circumstances where such removal is necessary to protect the interests of the Hospital. Each of the following conditions constitutes cause for removal:
   i. Failure to comply with or support enforcement of the Medical Staff Bylaws, Medical Staff Rules, Regulations, or policies.
   ii. Failure to perform the required duties of the office;
   iii. Failure to adhere to professional ethics;
   iv. Abuse of office;
   v. Conduct unbecoming a Medical Staff member; and
vi. Failure to continuously satisfy the qualifications set forth in Article IV. 4.2. of these Bylaws.

At least ten (10) days prior to the initiation of any removal action, the Member shall be given special Notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Medical Staff prior to a vote on removal.

(b) AUTOMATIC REMOVAL. Automatic removal is triggered (without need for vote) in the event of any of the following:
   i. Loss or suspension Medical or Dental license in the state of Indiana;
   ii. Ineligibility of membership in the Active Category of the Medical Staff;
   iii. Recommendation by the MEC to the Board for the imposition of Corrective Action or
   iv. Recommendation by the Board for Corrective Action.

(c) If the President is removed, he shall be ineligible to hold the office of Immediate Past President of the Medical Staff.

SECTION 5.8. VACANCIES. If the President is temporarily unable to fulfill the responsibilities of the office, the President-Elect shall assume these responsibilities until the President can resume those duties. When a permanent vacancy occurs in the office of President, the President-Elect will assume the office for the remainder of the existing term and thereafter serve this or her elected term as President. The MEC shall appoint a President-Elect to complete the term whenever this position is vacated. If the Immediate Past President resigns or is not eligible to hold this position, the President shall appoint another former President to fulfill the remainder of the term or it shall remain vacant until the current President becomes available to carry out the role.

ARTICLE VI.
CLINICAL SERVICES

SECTION 6.1. DESIGNATION OF CLINICAL SERVICES. The Medical Staff shall be divided into the following clinical services:

(a) Anesthesiology
(b) Cardiology
(c) Cardiovascular Surgery
(d) Emergency Medicine
(e) Family Medicine
(f) General Surgery
(g) Internal Medicine
(h) Medical & Surgical Neurology
(i) Neuromuscular Medicine
(j) Obstetrics & Gynecology
(k) Oncology
(l) Ophthalmology
(m) Oral & Maxillofacial Surgery & General Dentistry
(n) Otolaryngology
(o) Pathology
(p) Pediatrics
(q) Plastic Surgery
(r) Psychiatry
(s) Radiology
(t) Urology
The Board, with input from the MEC, may create additional Medical Staff Clinical Services upon request from at least three (3) Active Staff Members of a similar specialty interested in forming a Clinical Service, so long as this would improve the effectiveness of the Medical Staff in carrying out its responsibilities.

SECTION 6.2. ORGANIZATION OF CLINICAL SERVICES. Each clinical service shall be organized as a division of the Medical Staff and shall have a qualified Chair that has the authority, duties, and responsibilities set forth in these Bylaws. Each Clinical Service Chair is accountable to the oversight and authority of the MEC and the Board.

SECTION 6.3. FUNCTION OF CLINICAL SERVICES.

(a) Each Clinical Service shall perform any of the following:
   i. Provide a forum for discussion and for performing peer review and quality monitoring/improvements for clinicians in a particular specialty or interdisciplinary group of specialties.
   iii. Sponsor “grand rounds,” morbidity & mortality (M&M) Conferences, or clinical case conferences
   iv. Provide a vehicle for discussion of policies and procedures or equipment needs in a specialty or service line area.
   v. Create an opportunity for networking and collegial interaction among Physician, Dentists and Practitioners with common interests.
   vi. Develop recommendations for submission to the MEC, Quality Assurance Council of the MEC or the Credentials Committee.
   vii. Participate in the development of criteria for clinical privileges when requested for input by the Credentials Committee or MEC.
   viii. Participate in the development, implementation and enforcement of the on call coverage program and clinical protocols when asked by the MEC or an appropriate Medical Staff Committee.
   ix. Discuss a specific issue at the request of a Medical Staff Committee.

(b) Clinical Services are not request to hold regular meetings or keep minutes or track attendance. A written report to document a specific position is required only when the service is making a formal report to the MEC or any other standing committee of the Medical Staff. The President or the appropriate Medical Staff standing committee chair and the Clinical Service Chair will decide if the report is placed on the MEC or standing committee agenda and whether the Clinical Service Chief (or designee) will attend the MEC or other standing committee meeting to present the report and participate in the vote of the MEC or the standing committee on that specific issue.

(c) Clinical Service Member Accountability. Members assigned to the clinical service are accountable to the Clinical Service Chair and must be responsive to requests for information, participation in clinical service activities including: on-call requirements; peer review/performance monitoring and improvement; participation in a mandatory special meeting; and, compliance with Hospital and Medical Staff policies, procedures, or requirements assigned at the time of credentialing/privileging.

SECTION 6.4. CLINICAL SERVICE CHAIR.

(a) QUALIFICATION. Each Clinical Service Chair shall be:
   i. A member of the Active Staff Category:
   ii. Board Certified by a specialty recognized by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) or found to have comparable competency by actions of the Credentials Committee and MEC;
   iii. Qualified by experience within the Medical Staff and by administrative ability to supervise the functions of the Clinical Service, and
iv. Willing and able to discharge the functions of the Clinical Service and the responsibilities of the Clinical Service Chair of these Bylaws.

SECTION 6.5. RESPONSIBILITIES OF THE CLINICAL SERVICE CHAIR.

(a) Each Clinical Service Chair shall have responsibility for the organization and administration of the clinical service including:

i. Establishing with the MEC the type and scope of services to be provided by the respective Clinical Service in order to meet the needs of the patients and Hospital;
ii. Developing and implementing policies and procedures that support and guide the scope of services provided;
iii. Assessing and improving the quality of care and services provided by his/her Members of the Clinical Service. He must be familiar with all-ongoing quality measurements and quality assessment and improvement processes;
iv. Continuing surveillance of the performance of all individuals with clinical privileges;
v. Giving input regarding clinical privileging criteria as requested by the MEC or Credentials Committee;
vi. Being familiar with the credentialing process and giving input regarding clinical privileges for each clinical service member. He/She will use all available quality data in giving input to appointments/reappointments;
vii. Preparing and leading meeting of the Clinical Service to communicate to the Members the quality measurements, monitoring and improvements accomplished and in progress for the Clinical Service and the Hospital;
viii. Attending Clinical Service meetings and communicate to the Clinical Service Quality Measurements and improvements accomplished;
ix. Ensure compliance with the on call and other inpatient consultation and coverage policies and programs that may be established by the MEC;

(b) SELECTION.

i. Except as otherwise provided by a contract initiated and implemented by the Board, each Clinical Service Chair shall be elected by a plurality of the votes cast by Members of the Clinical Service in the Active Staff Category. Where the Board has determined the Chair will be filled through a contract mechanism, the Chair will be selected by the Hospital President and ratified by the Board. Members of the Clinical Service will be informally consulted for input on this decision and to give feedback to the Hospital CEO regarding the performance of the Clinical Service Chair. Elections will be held by written ballot at a Clinical Service meeting prior to the end of the current Chair’s term. If a vacancy shall arise, an election will take place at the next scheduled Clinical Service meeting to select an interim Chair to complete the full term. Elections will be organized and conducted by each Clinical Service in a manner satisfactory to the MEC.

ii. To be placed on the ballot, the member must meet the qualification in 5.4a and give assent.

(c) TERM.

i. Each Clinical Service Chair shall serve a term of two (2) years.

ii. A Clinical Service Chair may be elected for successive terms, unless otherwise provided by the MEC or Board.

SECTION 6.6. REMOVAL OF CLINICAL SERVICE CHAIR. Upon written petition by 25% of Clinical Service Members or upon recommendation of the MEC, the Medical Staff Office will arrange a recall vote at the next scheduled meeting of the Clinical Service. Removal may be accomplished by a two-thirds (2/3) vote of those eligible Members of the Clinical Service voting and following ratification of the action by the Board.
ARTICLE VII.
MEDICAL STAFF COMMITTEES AND LIAISONS

SECTION 7.1. TYPES OF COMMITTEES. There shall be an Executive Committee of the Medical Staff which is a standing committee of the Medical staff accountable to the MEC. Standing committees may be established in these Bylaws or created by the President, in collaboration with the MEC and with input from the Medical Staff, to accomplish Medical Staff functions. The Medical Staff may carry out responsibilities through participation in committees of the Hospital.

The current standing committees are: Credentials Committee, Quality Assurance Council of the MEC, Pharmacy and Therapeutics, Bylaws, Physician Assistance and Leadership Selection.

The Committee Charters and the Functions of the Medical Staff Standing Committees, except as indicated above, are outlined in the Medical Staff Policies and Procedures.

The President of the Medical Staff, in collaboration with the MEC, and with input from the Medical Staff, will assign physician membership to Standing and other Medical Staff or Hospital committees that are involved with clinical aspects of patient care. Other Medical Staff committees that may be formulated are generally time limited and/or ad hoc in nature to address specific matters which may occur episodically or on a recurring basis with relative infrequency.

All meetings of committees of the Medical Staff will be considered Peer Review meetings to the extent that their responsibilities include the evaluation of the qualifications of, or the patient care rendered by or the merits of a complaint against any Professional Health Care Provider as defined in Indiana Code § 34-6-2-117 which includes the Hospital, itself. As such, and all Members and personnel of the peer review committee shall enjoy all the rights, responsibilities, and protections of the Indiana Peer Review statute, including invoking the evidentiary privilege.

SECTION 7.2. COMMITTEE CHAIR.

(a) SELECTION. With the exception of the MEC and Clinical Service committees, the Chair and Vice Chair of each standing or special committee shall be appointed by the President of the Medical Staff, subject to the approval of the MEC. The President of the Medical Staff shall serve as Chair of the MEC, and the President Elect will Chair the Medical Staff Quality Council of the MEC.

(b) TERM: Unless specified otherwise in these Bylaws, each committee Chair shall be appointed to a term of two (2) years.

SECTION 7.3. MEMBERSHIP AND APPOINTMENT.

(a) ELIGIBILITY.

i. Active and Associate Medical Staff Members shall be eligible for appointment to any standing or other committee of the Medical Staff established to perform one or more of the functions required by these Bylaws. Only Active Medical Staff Members are eligible to serve on the MEC.

ii. Where specified in these Bylaws, or where the MEC deems it appropriate to the functions of a Medical Staff committee, Members of the Honorary Staff and representatives from various services of the Hospital, including, without limitation, Administration, Laboratory, Nursing, Information Management and Pharmacy Services, shall be eligible for appointment to specific committees of the Medical Staff.

(b) CHIEF EXECUTIVE OFFICER. Unless otherwise provided in these Bylaws, the Chief Executive Officer or designee shall be a member of all Medical Staff committees.

(c) VOTING. Only Medical Staff Members in the Active or Associate categories may vote on Medical Staff
committees, unless specified otherwise in these Bylaws or Medical Staff Policies and Procedures.

(d) **TERM.** Unless specified otherwise in these Bylaws, each medical Staff Committee member shall be appointed to a term of two (2) years, and may be reappointed as often as the individual or party responsible for such reappointment may deem advisable.

**SECTION 7.4 MEDICAL EXECUTIVE COMMITTEE.**

(a) **MEMBERSHIP.** All Active Medical Staff Members are eligible to serve on the MEC.

(b) **COMPOSITION.** The MEC shall consist of the following voting Members:

  i. President
  ii. President-Elect
  iii. Treasurer/Communications Officer
  iv. Credentials Committee Chair
  v. Immediate Past President (when invited to attend a particular MEC)
  vi. Eight (8) At-Large Active Staff Members with at least one Member being from each of the following areas: community based; hospital based; acute care medicine and acute care surgery.
  vii. The following are non-voting Members of the MEC: Hospital CEO, Hospital VPMA and the Hospital VP of Nursing, and a physician member of the Board.

The MEC may invite additional quests as needed to assist in carrying out its work. Any member may attend and observe any MEC meeting. Clinical Services Chairs may participate in the discussion of a MEC meeting at the request/approval of the President of the Medical Staff. Clinical Service Chairs are eligible to vote at the MEC consistent with Article V, Section 5.3 (b) of these Bylaws.

(c) **ELECTION AND APPOINTMENT OF MEC MEMBERS.** At Large Members of the MEC will be voted on using the same methodology as elections for Medical Staff Officers. Any Active Medical Staff member may be nominated by any member of the Medical Staff for an at-large position consistent with Article IV, Section 4.3 of these Bylaws. The Credentials Committee chair will be appointed by the President of the Medical Staff.

(d) **MEC RESPONSIBILITIES.**

  i. The MEC shall represent the Medical Staff, assume responsibility for the effectiveness of all medical activities of the Medical Staff, act on matters of concern and importance to the Medical Staff, and act at all times as the authorized delegate of the Medical Staff in regard to general and specific functions of the Medical Staff.
  ii. The MEC is empowered to act for the Medical Staff in intervals between general Medical Staff meetings.
  iii. The MEC receives and acts on reports and recommendations from Medical Staff committees, Clinical Services, Hospital committees, consultants, and other relevant individuals.
  iv. The MEC consults with Hospital senior management on quality-related aspects of contracts for patient care service with entities outside the Hospital.
  v. The MEC carries out Investigations in accordance with Volume II of these Bylaws before making recommendations to the Board to terminate, limit, or restrict a Member’s membership or privileges.
  vi. The MEC is responsible for making Medical Staff recommendations directly to the governing body for its approval. Such recommendations pertain to at least the following:
    a. The Medical Staff’s structure;
    b. The mechanism used to review credentials and to delineate individual clinical privileges;
    c. Recommendations of individuals for Medical Staff membership;
d. Recommendations for delineated clinical privileges for each eligible individual;

e. The participation of the Medical Staff in organization performance improvement activities;

f. The mechanism by which Medical Staff membership may be terminated;

g. The mechanism for investigation, Corrective Action and Fair Hearing Procedures; and

h. The review of actions on reports of Medical Staff Committees, Clinical Services, and other assigned activity groups,

(e) **REMOVAL.** Medical Staff members serving on the MEC will lose their membership on the MEC if removed from their position as an officer, clinical service or committee chair as described elsewhere in these Bylaws. At-large and appointed Members of the MEC may be removed by affirmative vote of two-thirds of the MEC membership. Grounds for removal include:

i. Failure to meet the attendance requirements;

ii. Disruptive conduct at MEC meetings; and

iii. Failure to carry out assigned duties. Members of the MEC will be considered to have voluntarily resigned from the committee if any of the following occur:

a. Termination or suspension of the member’s license to practice in the state of Indiana; Loss of membership on the Active category of the Medical Staff;

b. The MEC recommends to the Board that the member be subject to Corrective Action.

(f) **MEETINGS.** The MEC shall meet monthly, at least 10 times per year, and shall maintain a permanent record of all proceedings and actions at its meetings. The President of the Medical Staff or designee will preside at all meetings of the MEC.

(g) **CALL OF SPECIAL MEETING.** The President of the Medical Staff may call special meetings of the MEC at any time. Such meetings may be held in person or through telephonic or electronic conferencing.

**SECTION 7.5. MEDICAL STAFF REPRESENTATION ON HOSPITAL COMMITTEES.** In order to further carry out the functions of the Medical Staff and to provide Medical Staff input where appropriate, the President of the Medical Staff may appoint members to Hospital committees. The Hospital committees to which Medical Staff Members may be assigned may include, but are not limited to: Cancer, Infection Control, Program and Education, Graduate Medical Education, Bio-Ethics, Critical Care and Transfusion. When Medical Staff Members sit on a Hospital committee the minutes of that committee shall be available to the MEC. It shall be the responsibility of the Medical Staff member(s) sitting on a Hospital committee, to bring to the attention of the MEC or a Medical Staff Officer any matter brought before such committee that requires the attention of the Medical Staff Leadership.

**SECTION 7.6. SPECIAL OR AD HOC COMMITTEES OR MEDICAL STAFF LIAISONS.** The President of the Medical Staff or MEC may appoint ad hoc committees to address specific issues or concerns on behalf of the Medical Staff. In establishing such committees, there will be a notion made in the minutes of the MEC enumerating the committee’s purpose and charge, and timeframes for its work, and the duration of its appointment. Such committees will report to and be accountable to the MEC.
ARTICLE VIII.
GENERAL MEDICAL STAFF MEETINGS

SECTION 8.1. GENERAL MEDICAL STAFF MEETINGS.

(a) FREQUENCY & CONTENT. There shall be at least one meeting of the Medical Staff held each year during the fourth quarter. Written notice of the meeting shall be sent in a manner determined by the Medical Staff Office to all Medical Staff Members. The MEC shall determine the time and place at which the meeting shall be held. The President of the Medical Staff or MEC may call additional general meetings for any reason they deem appropriate, including to promote communication with the Medical Staff, provide a forum for discussion on matters of Medical Staff interest, review quality and safety data and concerns, present education programs, or address proposed changes to the Medical Staff Bylaws.

SECTION 8.2. SPECIAL MEETINGS OF THE MEDICAL STAFF.

(a) CALL OF SPECIAL MEETING. A special meeting of the Medical Staff may be called at any time by the President of the Medical Staff, and shall also be called at the request of the Board, the MEC or in response to a petition presented to the President of the Medical Staff and signed by twenty percent (20%) of the Active Staff. No business shall be transacted at any special meeting, except that for which the meeting is called and stated in the Notice of such meeting.

(b) NOTICE. Notice stating the time, place and purpose(s) of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each member of the Medical Staff in a manner determined by the Medical Staff Office at least seven (7) days before the date of such meeting. The attendance of a member of the Medical Staff at the meeting shall constitute a waiver of Notice of such meeting.

SECTION 8.3. ATTENDANCE AT MEETINGS. Members of the Medical Staff are encouraged to attend General Medical Staff meetings.

SECTION 8.4. QUORUM. Those Active Staff Members present and voting shall constitute a quorum at any meeting, unless otherwise specified in these Bylaws.

SECTION 8.5. MINUTES. Minutes of each regular and special meeting of the Medical Staff shall be prepared and shall include a record of attendance of Members and any votes taken on matters presented at the meeting. The minutes shall be signed by the presiding officer and maintained in a permanent file in the Medical Staff Office.

SECTION 8.6. CONDUCT OF MEETINGS. Meetings of the Medical Staff and meetings of committees and Clinical Services (as described in Volume I and III of these Bylaws) will be run in a manner determined by the chair or designee who shall preside. Compliance with rules of parliamentary procedure is not required.

ARTICLE IX.
COMMITTEE AND CLINICAL SERVICE MEETINGS

SECTION 9.1. REGULAR MEETINGS. Clinical Services and Committees may, by resolution, establish the time for holding meetings without providing Members Notice other than by announcement such resolution in meeting minutes.

SECTION 9.2. SPECIAL MEETINGS. A special meeting of any Committee or Clinical Service may be called by or at the request of the Chair thereof, by the President, or by written request signed by twenty-five (25%) of the current Members of the Committee or Clinical Service, but not by fewer than (2) such members. Such meetings will be held within a reasonable period of time after their request. The request, regardless of how initiated, shall note the purpose of the meeting.
SECTION 9.3. NOTICE OF MEETINGS. Written or oral notice stating the place, day, and hour of any special meeting or any regular meeting, to each member of the committee or Clinical Service that is to meet, not less than five (5) days before the time of such meeting. If mailed, the Notice of the meeting shall be posted to the member, at his address as it appears on the records of the Medical Staff, at least seven (7) days before the meetings. The attendance of a member at a meeting shall constitute a waiver of Notice of such meeting.

SECTION 9.4. PURPOSE OF THE MEETING. Any notice provided shall include the purpose of the meeting.

SECTION 9.5. QUORUM. A quorum for the MEC will be more than 50% of the voting membership of the committee in attendance in person or via telephonic or electronic conferencing.

SECTION 9.6. MANNER OF ACTION. The action of a majority of the Members present at a meeting at which a quorum is present shall be the action of a committee or clinical service. Action may be taken without a meeting by unanimous consent in writing, setting forth the action so taken and signed by each Member who would be entitled to vote at that meeting.

SECTION 9.7. MINUTES. Minutes of required committees and any special meetings shall be prepared, including a record of the Members in attendance and the results of any votes taken at the meeting. The minutes shall be signed by the presiding officer and copies thereof shall be submitted to the attendees for approval. All minutes shall be available to the MEC. Each committee shall maintain a permanent file in the Medical Staff Office of the minutes of each meeting.

SECTION 9.8. ATTENDANCE REQUIREMENTS. Members of the MEC, Credentials Committee, and Quality Assurance Council of the MEC are expected to attend at least 75% of committee meetings held each year. Failure to attend at least 50% of the meetings will make the member eligible for removal by action of the President with ratification by the MEC.

SECTION 9.9. MANDATORY SPECIAL APPEARANCE REQUIREMENT. Mandatory attendance is required when requested by the MEC, The Chair of the Quality Assurance Council of the MEC, the Chair of the Credentials Committee or a Clinical Service in Collaboration with the CMO. Failure by any person to attend any meeting to which he was given Notice that attendance was mandatory, unless excused by the MEC upon showing of good cause, shall result in an automatic suspension of all or such portion of the Member’s or Practitioner’s clinical privileges as the MEC may direct, and such suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate, including, without limitation, Corrective Action. Such persons may make timely request for postponement of such meeting supported by an adequate showing that his absence will be unavoidable, in which case the presentation may be postponed for up to four weeks, at the discretion of the Chair of the Committee or Clinical Service, the President or the MEC if the President is the person is involved.

ARTICLE X.
CONFIDENTIALITY, IMMUNITY, AUTHORIZATIONS AND RELEASES

SECTION 10.1. AUTHORIZATIONS AND RELEASES. Each Physician, Dentist or Practitioner shall, when requested by the Hospital, execute general and specific releases and provide documents when requested by the President of the Medical Staff, Chair of the Credentials Committee or Quality Assurance Council of the MEC, the Hospital CEO or their respective designees. Failure to execute such releases or provide requested documentation shall result in an application for appointment, reappointment, and/or clinical privileges being deemed voluntarily withdrawn, and it shall not be further processed.

By submitting an application for Medical Staff appointment or reappointment, or by applying for or exercising privileges or providing specific patient care services within the Hospital, all Physicians, Dentists and Practitioners, as appropriate, without limitation:
(a) Authorize representatives of the Hospital and the Medical Staff to solicit procure, provide, and/or upon information bearing on or reasonably believed to bear upon the Practitioner’s professional abilities and qualifications;

(b) Agree to be bound by the provisions of these Bylaws and Hospital policies, Medical Staff Rules, Regulations and Policies regardless of whether membership or clinical Privileges are granted or subsequently restricted;

(c) Acknowledge that the provisions of this Article are express conditions to an application for, or acceptance of, staff membership, and the continuation of such membership and/or the exercise of clinical privileges or provision of specified patient care services at the Hospital;

(d) Agree to release from legal liability and hold harmless the Hospital, Medical Staff, and any representative of the Hospital or Medical Staff who acts to carry out Medical Staff or Hospital policies or functions, including all persons engaged in peer review and performance improvement activities.

(e) Agree that his sole remedy for any adverse recommendation or action taken through the peer review activities of any professional peer review body for failure to comply with these Bylaws or Medical Staff or Hospital policies, will be the right to seek legal or equitable relief only after exhausting all rights and remedies in these Bylaws.

(f) Agree to release from the legal liability and hold harmless any individual who or entity which provides information (including peer review information) regardless the Practitioner to the Hospital or its representatives;

(g) Authorize the release of information (including peer review information) about the Practitioner to other entities in the Health System where the Practitioner has or requests membership or privileges.

SECTION 10.2. CONFIDENTIALITY. Information with respect to any Physician, Dentist, or Practitioner submitted, collected or prepared by any representative of this Hospital, Health System, or any other health care facility or organization or Medical Staff, for the purpose of evaluating and improving performance and patient care, reducing morbidity or mortality, promoting efficiency, or contributing to medical education or clinical research, shall, to the fullest extent permitted by law, be confidential. Confidential information shall not be disseminated to anyone other than a representative(s) of the Hospital or the Medical Staff with a legitimate need for access in order to carry out required functions or third party health care entities performing legitimate credentialing and peer review activities. Such confidentiality shall also extend to information of like kind that may be provided by third parties.

SECTION 10.3. IMMUNITY FROM LIABILITY.

(a) FOR ACTIONS TAKEN. Representatives of the Hospital, and the Medical Staff shall have immunity from any and all liability in any judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of their duties as such representatives.

(b) PROVIDING INFORMATION. Representatives of the Hospital, the Medical Staff and any third party shall have immunity to the fullest extent of the law from any and all liability in any judicial proceeding for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of the Hospital, the Medical Staff, the Health System or to any other Hospital, organization or health professionals, or other health-related organizations, concerning any Professional Health Care Provider as defined under the Indiana Peer review Statue who are or have been an applicant to, or Member of the Staff, or who did or does exercise privileges or provide services at this Hospital.

SECTION 10.4. ACTIVITIES AND INFORMATION COVERED.

(a) ACTIVITIES. The provisions of this Article shall apply to acts, communications, reports, recommendations, or disclosures in connection with this or any other health-related institution’s or organization’s activities concerning, but not limited to:

i. Applications for appointment, clinical privileges or specified services;

ii. Periodic reappraisals for reappointment, clinical privileges or specified services;
iii. Disciplinary measures, including warning and reprimands;
iv. Investigations and corrective actions;
v. Hearings and appellate reviews;
vi. Performance improvement activities including the creation and dissemination of performance profiles;
vii. Peer review activities including external peer review;
viii. Utilization and claims review;
vii. Other Hospital, Clinical Service or committee activities related to monitoring and maintaining of quality patient care and appropriate professional conduct.

(b) INFORMATION. The acts, communications, reports disclosures, and other information referred to in this Article may relate to a Practitioner’s professional qualifications, clinical or procedural abilities, judgment, character, physical and mental health, emotional stability, professional ethics, professional conduct or any other matter that might directly or indirectly affect patient care.

SECTION 10.5. CUMULATIVE EFFECT. Provisions in these Bylaws and in application forms relating to authorizations, releases, confidentiality of information, and immunities from liability shall be in addition to other protections provided by local, state and federal law and not in limitation thereof.

ARTICLE XI.
GENERAL PROVISIONS

SECTION 11.1. MEDICAL STAFF RULES, REGULATIONS, AND POLICIES. Subject to approval by the Board or its designee, the Medical Staff shall adopt such Rules, Regulations and Policies as may be necessary to carry out the responsibilities and functions of the Medical Staff and implement its operations. There shall be no substantive distinction between Rules, Regulations and Policies.

SECTION 11.2. PAYMENT OF FEES. All Members are required to pay an initial and reappointment fee in an amount determined by the MEC and ratified by the Board.

SECTION 11.3. JOINT CONFERENCE. Whenever the Board’s proposed decision will be contrary to the MEC’s recommendation, the Board shall submit the matter to a Joint Conference of an equal number of Medical Staff and Board Members for review and recommendation before making its final decision and giving Notice of final decision. Individuals participating in a Joint Conference will be appointed by the President of the Medical Staff and Chair of the Board. The Joint Conference Committee will submit its recommendation to the Board and to the party requesting the Joint Conference. The Board will then take final action on the matter. Such action will not be subject to further deliberation. The MEC or the Board may also request the convening of a Joint Conference to discuss any matter of controversy or concern that would benefit from enhanced dialogue between Medical Staff and leaders.

SECTION 11.4. CONFLICT RESOLUTION PROCESS. Unless otherwise set forth in the Medical Staff Bylaws or Hospital Bylaws, the Medical Staff, in partnership with the Board, establishes the following process for addressing conflicting recommendations made by the Board and the Medical Staff.

(a) The Medical Staff, in partnership with the Board will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, the communities we serve, and the Members of the Medical Staff.
(b) When the Board plans to act or is considering acting in a manner contrary to a recommendation of the MEC, the Medical Staff Officers shall meet with the Board, or a designated committee of the Board and management and seek to resolve the conflict through information discussions.
(c) If these information discussions fail to resolve the conflict, the Medical Staff President or the Chair of the Board may request initiation of a formal conflict resolution process.
(d) The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process to address the conflict.
(e) The Joint Conference Committee shall be comprised of MEC representatives and/or designees, Board Members and/or designees, and the CEO or designees.

(f) If the Joint Conference Committee cannot produce a resolution to the conflict acceptable to the MEC and the Board within thirty (30) days of this initial meeting, the Medical Staff and the Board shall enter into mediation facilitated by a mediator with specialization in health care law.

(g) The MEC and Board shall agree upon the selection of the third party mediator.

(h) The MEC and Board shall make best efforts to collaborate together and with the mediator to resolve the conflict. The Board and the MEC shall each designate at least three (3) people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approvals of the MEC and the Board which are set forth in the Medical Staff Bylaws and the Articles of Incorporation and Bylaws of the Hospital.

(i) If, after ninety (90) days from the date of the initial request for mediation, the MEC and Board cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

(j) If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in order to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance or other critical obligations of the hospital, the Board may take action which will remain in effect only until the conflict resolution process is completed.

ARTICLE XII.
ADOPTION AND AMENDMENT OF MEDICAL STAFF GOVERNING DOCUMENTS

SECTION 12.1. FORMULATING AND REVIEWING BYLAWS AMENDMENTS. The Medical Staff shall have the responsibility to formulate, review at least biennially, and recommend to the Board any Medical Staff Bylaws, Regulations, Policies, Procedures and amendments as needed, which shall be effective when approved by the Board. The Medical Staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership. Neither the Board nor the Medical Staff shall unilaterally amend the Medical Staff Bylaws.

SECTION 12.2. METHODS OF ADOPTION AND AMENDMENT TO THE BYLAWS. The Bylaws may be amended at any time by a proposal from the MEC or by written petition with an explanation of the position signed by twenty percent (20%) of the Members of the Active Staff Category. A proposed amendment shall be reviewed by the MEC and disseminated to all Member of the Active Staff. The MEC shall present the proposed amendment with its recommendation to the Active Members for a vote. Each Active Member will be eligible to vote on the proposed amendment to these Bylaws via printed or secure electronic ballot in a manner determined by the MEC. All Active members of the Medical Staff shall receive at least thirty (30) days advance Notice of the proposed amendment prior to a vote. To be adopted, such proposed amendment must receive an affirmative vote of a majority of the votes cast by the Active Members of the Medical Staff. All ballots must be marked in the affirmative or negative to be considered in any final vote count. Votes will be counted by the MEC on the "count date" listed on each ballot. Ballots submitted after that time shall not be counted.

SECTION 12.3. AMENDMENT OF MEDICAL STAFF RULES AND REGULATIONS AND MEDICAL STAFF POLICIES AND PROCEDURES. Amendments to the Medical Staff Policies and Procedures and shall be effective when approved by the affirmative vote of two thirds (2/3) of the MEC and subsequent approval by the Board. The MEC shall distribute a copy of the proposed amendments to the Medical Staff within one week of the MEC meeting where the proposed changes were approved by the MEC. Voting Members of the Active Medical Staff may submit comments to the President of the Medical Staff prior to the upcoming meeting where the changes will be considered, concerning the MEC’s proposed amendments.

SECTION 12.4. TECHNICAL CHANGES TO THE BYLAWS. The MEC may adopt such amendments to Medical Staff Bylaws, Rules, Regulations, and policies that are, in the committee’s judgment, technical or legal
modifications or clarifications, consist of reorganization or renumbering of material, or are needed due to punctuation, spelling, or other errors of grammar of expression. Such amendments must be ratified by the Board.

**SECTION 12.5. METHOD FOR MEDICAL STAFF MEMBERS TO SUBMIT BYLAWS AMENDMENTS.** Any Medical Staff Member may also submit amendments or request repeal of the Bylaws and Medical Staff Policies and Procedures directly to the Board. The Member must first obtain a petition signed by twenty percent (20%) of the Active Medical Staff Members supporting their position and communicate their intent to the MEC. Proposed amendments submitted by the Medical Staff Member will be forwarded to the Board with the MEC’s recommendation if different from that of the Medical Staff member.

**SECTION 12.6. ADOPTION OF THE BYLAWS.** These Bylaws, upon adoption by the Medical Staff shall replace and supersede existing Bylaws and shall become effective when approved by the Board. They shall, when adopted and approved, be equally binding on the Board and the Medical Staff.

Adopted by
MEC: May 19, 2015
Governing Board: August 10, 2015