RULES AND REGULATIONS

OF

THE MEDICAL STAFF

HOWARD REGIONAL SPECIALTY CARE, L.L.C.

dba

COMMUNITY HOWARD SPECIALTY HOSPITAL

Approved by the Board of Managers of Howard Regional Specialty Care, L.L.C.
dba Community Howard Specialty Hospital **June 15, 2016**.

TABLE OF CONTENTS

Page

A. PREAMBLE: 1

B. ADMISSION OF PATIENTS: 1
1. Custodial Care/Transfer for Services 1
2. Contagious Disease 1
3. Eligibility to Admit 1
4. Provisional Diagnosis 1
5. Provisional diagnosis 1
5. Preadmission Screenings 1
6. Plan of Treatment 1
7. Multidisciplinary Team 2

C. MEMBER COVERAGE 2

D. CONSULTATIONS 2
1. Appropriateness 2
2. Responsibility 2
3. Consulting by Associates 2
4. Required Consultations 2
5. Consultation Timeframe 3

E. TERATMENT ORDERS 3
1. Computerized Physician Order Entry 3
2. Member Order 3
3. Telephone/Verbal Orders 3
4. Office Staff 3
5. Countersignatures 3

F. ROUTINE STANDING ORDERS 4
1. Requirements 4
2. Initial Approval/Annual Review 4
3. Additions 4
4. Reproduction on Order Sheet 4

G. MEDICAL RECORDS 4
1. Requirements 4
2. Content 4
3. Progress Notes 4
4. Authentication 5
5. Electronic Signature 5
6. Symbols and Abbreviations 5
7. Final Diagnosis 5
8. Discharge Summary 5
9. Ownership 5
10. Release of Information 5

11. Readmissions 5
12. Unauthorized Removal 5
13. Permanent Filing 5
14. Completion of Medical Record 5
15. Incomplete medical records: 6

H. DRUGS AND MEDICATIONS 6
1. Use of Approved Drugs 6
2. Formulary System 6
3. Generic Equivalency 6

I. UTILIZATION REVIEW 6
1. Documentation of Need 6
2. Written Justification 7

J. RELEASE OF INFORMATION 7
1. Authorization 7
2. Removal from Hospital 7

K. MEDICAL STAFF DISASTER ASSIGNMENTS 7
1. Assignment of Physicians 7
2. Relinquishment of Care 7

L. DISASTER PRIVILEGES. 7
1. Qualifications 7
2. Procedure 8
3. Duration 8
4. Assignment/Supervision 8

M. CONSENTS 8
1. General Consent 8
2. Special Consent 8
3. Informed Consent 8
4. Approval of Consent/Documentation 9
5. Nursing Staff 9
6. Exceptions 9
7. Telephone Consent 9
8. Refusal of Consent 9
9. Living Wills 10
10. Termination of Life Support 10
11. Compliance with Living Wills 10
12. Organ Donation 10

N. DO NOT RESUSCITATE 10
1. Definition 10
2. Guidelines: 10
3. Procedures: 11

O. CME RULE 11
1. Requirements 11
2. Noncompliance 11

P. NOTIFICATION REQUIREMENTS 12
1. Letters of Notification 12
2. Confidentiality 12
3. Forward to Committee 12
4. Failure to Comply 12

Q. REGULATORY REQUIREMENTS: 12

RULES AND REGULATIONS
OF
THE MEDICAL STAFF OF HOWARD REGIONAL SPECIALTY CARE, L.L.C.

dba COMMUNITY HOWARD SPECIALTY HOSPITAL

A. PREAMBLE:

The Medical Staff of the Howard Regional Specialty Care, L.L.C. dba Community Howard Specialty Hospital (the "Hospital") has adopted these Rules and Regulations of the Medical Staff to provide guidance for the proper conduct of the work of the Medical Staff. These Rules and Regulations shall be a part of the Medical Staff Bylaws ("Bylaws") of the Hospital and may be amended pursuant the Bylaws. All terms not otherwise defined herein shall have such meaning as given to them in the Bylaws.

B. ADMISSION OF PATIENTS:

1. Custodial Care/Transfer for Services. The Hospital will accept any patient needing rehabilitative care or treatment but shall not continue service for patients requiring only custodial care. Patients requiring facility, services or medical competence not available at the Hospital will be transferred or referred to a facility where more appropriate care can be provided.

2. Contagious Disease. Those patients with a contagious disease or with a provisional diagnosis of such disease shall be admitted for care only when appropriate isolation facilities are available.

3. Eligibility to Admit. Only Physicians who have been granted Medical Staff Membership and delineated Clinical Privileges shall be permitted to admit, exam, treat, or prescribe treatment for any patient at the Hospital, subject to the conditions described herein. Allied Health Professionals shall be permitted to examine and treat patients as delineated by the Clinical Privileges granted to the AHP.

4. Provisional Diagnosis. The Member requesting the admission of a patient must provide a provisional diagnosis for that patient. In case of an emergency, the provisional diagnosis shall be stated not later than twenty-four (24) hours following admission. This information is required to protect the patient, other patients, visitors, and Hospital personnel.

5. Preadmission Screenings. Each prospective patient shall undergo a preadmission screening procedure under which his or her condition and medical condition are reviewed to determine whether the prospective patient is likely to benefit significantly from an intensive inpatient rehabilitative program or assessment.

6. Plan of Treatment. Each patient admitted to the Hospital shall have a plan of treatment established, reviewed and revised as needed by the admitting Member in consultation with other professional personnel who provide services to the patient.

7. Multidisciplinary Team. Each patient admitted to the Hospital shall have rehabilitations services provided to them using a coordinated multidisciplinary team approach, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and by team conferences that are held at least every two weeks to determine the appropriateness of treatment.

C. MEMBER COVERAGE

A Member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital at all times. From time to time an "on-call" Physician may provide temporary coverage for a Member without officially transferring the case. The "on-call" Physician must be a Member of the Medical Staff and shall have privileges and credentials appropriate for the diagnosis and medical condition of the patient. Members must notify nursing staff of the current "on-call" roster or schedule. Failure to provide for appropriate care as delineated elsewhere in the Medical Staff Bylaws and Rules and Regulations shall be reported to the appropriate Medical Staff Department for consideration of disciplinary action.

D. CONSULTATIONS

1. Appropriateness. In all cases in which there is doubt as to the best therapeutic measures to be utilized, consultation is appropriate. Judgment as to the serious nature of the patient's condition and questions of doubt as to the diagnosis and treatment rests with the Member responsible for the care of the patient.

2. Responsibility. It is the responsibility of the Chief of the appropriate Department and the Medical Staff Executive Committee to see that Members do not fail in the matter of calling consultants as needed. The consultant must be a Physician or Allied Health Professional who is well qualified to give an opinion in the field in which his/her opinion is sought. A satisfactory consultation includes examination of the patient with a written record and opinion signed by the consultant which is made a permanent part of the record.

3. Consulting by Associates. Consultation by Physicians or Allied Health Professionals associated in the same office as the admitting Member should be avoided insofar as possible. In cases in which consultation is required by the rules of the Hospital, these services may be given without charge. In circumstances of grave urgency, or where consultation is required by rules of the Hospital, the President, in consultation with the Chief of Staff or Vice Chief of Staff or the Department Chief of the appropriate Department, shall at all times have the right to call in a consultant or consultants.

4. Required Consultations. Except in an emergency, consultation is required:

   a. when requested in writing by the patient or family;

   b. when a patient has attempted suicide or has taken an overdose of medication. In such instances, a psychiatric consultation shall be obtained.

5. Consultation timeframe. Medical staff members are required to see a patient within 72 hours of request for consult or as directed by requesting physician. Consulting physician has the right to decline consult which should be documented in the medical record. If the medical staff member does not meet this requirement then the following will result:

   a. First offense: Failure to provide timely communication of declination of consult on a consistent basis will result in a warning letter issued by Medical Director.

   b. Second offense: Privileges could be revoked.

E. TREATMENT ORDERS

1. Computerized Physician Order Entry. All orders must be entered on the Physicians Order Form (POF) or through Computerized Order Entry (CPOE). The physician extender or AHP may enter dictated physician orders on the POF or via CPOE, however, the physician must sign such records prior to leaving the patient care unit. Only those abbreviations and symbols approved by the Medical Staff Executive Committee and published as part of the Hospital's approved abbreviation list and approved "Do Not Use" abbreviation list may be used when documenting in the patient medical records.

2. Member Order. All orders must be written on the order sheet of the patient's medical record.

3. Telephone/Verbal Orders. Nursing Administration may determine which professionally licensed nurses may accept or implement verbal or written Member orders. Only Physician Members may give a verbal order so long as such orders are limited to the department from which the service is requested (e.g. a physical therapist may accept only orders related to physical therapy) and staff taking the verbal orders are operating within their scope of practice. The recording of verbal or telephone orders shall be done in accordance with Hospital policy and shall include the name and title of each person involved.

4. Office Staff. The office staff of a Member, acting at the Member's request, may fax orders that are dated and signed by the Member to a qualified professional as specified above. Office staff are not permitted to call in a Member order.

5. Countersignatures. The recording of such orders shall be done in accordance with Hospital policy and shall include the name and title of each person involved. The individual accepting the order shall be responsible for recording it, reading back and verifying on the medical record. The responsible Member shall countersign, date and time such orders within thirty (30) days.

6. Written Orders. Orders written by Mid-Level Professionals (MLPs) shall be co-signed by sponsoring physician by end of day.

F. ROUTINE STANDING ORDERS

1. Requirements. A Member may establish routine standing orders in accordance with the following standards:

   a. Schedule II controlled substances shall not be included in routine standing orders.

   b. The routine standing order must identify the classification of orders (e.g. routine admission, diagnosis specific, etc.).

   c. Routine orders will be initiated by the Hospital personnel only upon the specific order of the Member to do so.

2. Initial Approval/Annual Review. All routine standing orders must be initially approved by the Medical Staff Executive Committee. All routine standing orders will be reviewed annually by the chief of the appropriate Department. Only routine standing orders that have been approved by the Medical Staff Executive Committee will be utilized in the Hospital.

3. Additions. Any request for additions to a set of routine standing orders must be submitted to the Medical Staff Executive Committee for approval.

4. Reproduction on Order Sheet. Routine standing orders shall be reproduced in detail on the order sheet of the patient's record, dated and signed by the Member.

G. MEDICAL RECORDS

1. Requirements. A medical record shall be completed for each patient in a manner which is consistent with State law and with the standards of the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") and which provides adequate documentation for the provision of appropriate care. Each Medical Staff Member will be given access to the electronic medical record through creation of a password. Each Member must properly safeguard their password in accordance with hospital policy.

2. Content. The admitting Member shall have primary responsibility for the medical record for each patient. The medical record shall include all information and data as required by the Hospital's policies and procedures pertaining to medical records.

3. Progress Notes. Progress notes shall be recorded daily at the time of patient observation. The content of the progress note must be sufficient to permit the continuity and transferability of the patient's care. Each of the patient's clinical complaints should be clearly identified and addressed in the progress notes and correlated with special orders. The progress note must also contain the results of the latest tests and treatments performed. The progress note, as with all clinical entries in the patient's medical record, shall be accurately dated and authenticated.

4. Authentication. All treatment orders and certifications of diagnoses must be authenticated by written or electronic signature.

5. Electronic Signature. Electronic signature of dictated and transcribed documents is allowed per Hospital policy.

6. Symbols and Abbreviations. Only those symbols and abbreviations may be used in the medical record which have been approved by the Medical Staff. An official record of the approved abbreviations and approved "Do Not Use" abbreviations will be kept on each of the nursing units.

7. Final Diagnosis. Final diagnoses shall be recorded in full without the use of symbols or abbreviations. Final diagnoses must be dated and signed by the Member at the time of discharge of the patient.

8. Discharge Summary. The medical record of each patient discharged from the Hospital shall contain a written or dictated discharge summary signed by the responsible Member.

9. Ownership. All medical records are the property of the Hospital. All Members shall maintain and protect the privacy and confidentiality of all medical records in accordance with Federal and State laws and regulations governing the protection and confidentiality of medical records, health information and privileged communications.

10. Release of Information. The Member shall be notified of the release of any part of the medical record to the patient or to any third party except for the routine requests of third party payors. The Member may issue a written order withholding the release of the medical record or specific information in the medical record to the patient or to an identified third party, if the Member reasonably determines that the release of the information would be detrimental to the physical or mental health of the patient or is likely to cause the patient to harm him/herself or others.

11. Readmissions. Copies of the patient's medical record of previous admissions to the Hospital shall be made available to the Member upon request.

12. Unauthorized Removal. The unauthorized removal of medical records from the Hospital shall be grounds for suspension of Medical Staff or Clinical Privileges for a period to be determined by the Medical Staff Executive Committee.

13. Permanent Filing. No medical record shall be permanently filed until it is completed by the appropriate Member(s) or is ordered filed by the Medical Staff Executive Committee.

14. Completion of Medical Record. All Members shall strive to have the patient's medical record complete at the time of discharge, including progress notes, final diagnosis and (dictated) clinical resume. When this is not possible because certain information is not yet available at the time of discharge, the patient's medical record will be available for completion in a designated area.

15. Incomplete medical records:

a. In order to facilitate timely billing, Members are required to complete all components of the medical record prior to hospital billing. Members are required to record the patient's discharge diagnosis at the time of discharge. Any information necessary to complete the billing/coding process must be provided within seven (7) days of the request. All other components of the medical record must be dictated and signed within thirty (30) days of the patient's discharge. Failure to complete the medical record within thirty (30) days of the patient's discharge could result in the suspension of Medical Staff membership and/or Clinical Privileges until such delinquency is corrected.

b. Admission of patients by a Member under another Member's name will result in loss of all Medical Staff membership and/or Clinical Privileges for both Members for thirty (30) days, except both Members shall be allowed to provide follow-up care for those patients hospitalized at the time the loss of the Member's Medical Staff membership and/or Clinical Privileges becomes effective.

c. Members repeatedly delinquent in completing medical records in a timely and accurate manner will be reported to the Medical Staff Executive Committee who may take appropriate action as warranted by the circumstances.

H. DRUGS AND MEDICATIONS

16. Use of Approved Drugs. All drugs and medications to be administered to patients must be approved by the Federal Food and Drug Administration ("FDA"). The Pharmacy and Therapeutics Committee may review any order or proposed order of an FDA approved drug for a non-FDA approved purpose. Except in emergencies, use of drugs which have not been approved by the FDA is prohibited within the Hospital without prior written consent of the Hospital Pharmacy and Therapeutics Committee.

17. Formulary System. The Hospital's formulary system, approved by the Medical Staff, shall govern the procurement, prescribing, dispensing and administration of drugs within the Hospital.

18. Generic Equivalency. A Hospital pharmacist shall be authorized to dispense and administer another brand of a generically-equivalent product identical in dosage, form and content of active therapeutic ingredients and/or medication and that is proven to be as therapeutically effective as the ordered medication, if the medication has been approved by the Pharmacy and Therapeutics Committee and placed on the Hospital formulary.

I. UTILIZATION REVIEW

1. Documentation of Need. Members are required to document the need for continued hospitalization of a patient after specific periods of stay, as requested.

This documentation must include:

a. an adequate, written, record of the reason for continued hospitalization;

b. the estimated period of time the patient will need to remain in the Hospital; and

c. plans for post-hospital care.

2. Written Justification. Upon request of the utilization review coordinator, the admitting Member must provide written justification of the necessity for continued hospitalization, including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within twenty-four (24) hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Medical Staff Executive Committee for action.

J. RELEASE OF INFORMATION

1. Authorization. Written authorization shall be obtained from the patient or the patient's representative for the use and/or disclosure of health information as required by all State and Federal laws and regulations.

2. Removal from Hospital. Medical records shall not be removed from the Hospital without the written authorization of the President.

K. MEDICAL STAFF DISASTER ASSIGNMENTS

1. Assignment of Physicians. All Members of the Medical Staff shall be assigned to patient triage or treatment areas in the event of a disaster in accordance with the Hospital's Internal Disaster Plan.

2. Relinquishment of Care. All policies concerning patient care will be the joint responsibility of the Chief of Staff and the President. In their absence, the Vice Chief of Staff and the designated administrator, respectively, shall have such authority. All Members specifically agree to relinquish direction of the professional care of their patients to the Chief of Staff in case of such an emergency.

L. DISASTER PRIVILEGES.

In the event that the Hospital's emergency management plan is activated in response to a declared disaster or emergency, the President (or his/her designee) or Medical Director (or his/her designee) may grant disaster privileges to a licensed independent practitioner ("LIP").

1. Qualifications. Such LIP's offering their services must provide one (1) or more of the key documents listed below, in addition to a valid photo identification issued by a state or federal agency (for example, a current driver's license):

a. A current Indiana hospital photo identification card identifying the individual as a Physician or an Allied Health Professional (an expiration date must be printed on the photo identification as well as the name of the issuing hospital);

b. A current license issued by the applicable Indiana licensing Board;

c. Identification indicating that the LIP is a member of a state or federal disaster medical assistance team; or

d. Identification indicating that a federal, state, or municipal entity grants the LIP the authority to care for patients in emergencies.

e. Identification by current hospital or medical staff member(s) who possess personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster.

2. Procedure. The Medical Staff shall verify the credentials of individuals who receive disaster privileges within 72 hours from the time the volunteer practitioner presents to the organization and/or as soon as the immediate situation has stabilized. This verification will be a high priority to insure high quality patient care.

3. Duration. The granting of emergency privileges to the LIP's shall credential the LIP for the duration of time necessary to meet the health care needs of the organization while the emergency management plan is activated, as determined by the President (or his/her designee) or the Medical Director (or his/her designee).

4. Assignment/Supervision. A LIP granted disaster staff privileges will be assigned to function in areas appropriate to the LIP's specialty based upon the needs of the Hospital and shall be assigned to work under the direct supervision of a Medical Staff Member within the same specialty.

M. CONSENTS

1. General Consent. A general consent for admission and treatment at the Hospital shall be obtained for each patient admitted to the Hospital at the time of admission. Such consent shall be signed by the patient or the patient's representative

2. Special Consent. In addition to the general consent obtained for admission to and treatment at the Hospital, special consent forms shall be prepared and signed by the patient or the patient's representative for procedures, treatments, examinations or tests that bear significant risks to the patient.

3. Informed Consent. The Member who is to perform the procedure is responsible for informing the patient of the following:

a. the nature of the proposed care, treatment, services, medications, interventions, or procedures

b. potential benefits, risks, or side effects, including potential problems that might occur during recuperation

c. likelihood of achieving goals

d. reasonable alternatives

e. the relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment and services

f. when indicated, any limitations on the confidentiality of information learned from or about the patient

4. Approval of Consent/Documentation. Special consent forms shall be reviewed and approved by the Medical Staff Executive Committee; in addition, any Member shall document in a progress note the content of a discussion with the patient or the patient's representative pertaining to obtaining consent to perform the procedure, treatment, examination or test, if, in the judgment of the attending Member, such an entry is appropriate.

5. Nursing Staff. At the request of the attending Member, nursing staff will tender a consent form to the patient or the patient's representative to obtain consent and verify that attending Member has reviewed required information to satisfy informed consent as listed in these Rules and Regulations under M. Consents, 3. Informed Consent. If the patient has any questions about the procedure, treatment, examination or test, or is in any way unsure of its nature, the expected outcomes, material risks or reasonable alternatives to the procedure, treatment, examination or test, the nursing staff will discontinue the attempt to obtain the patient's consent and will immediately notify the attending Member of the need to discuss the matter further with the patient. Similarly, if there is any question of the competency of the patient to understand any of the elements of informed consent listed above, the nursing staff will immediately contact the attending Member and request that he or she obtain the patient's signature and to make an entry into the medical record documenting the Member's judgment that the patient is competent to give consent.

6. Exceptions. When a situation exists which requires immediate action of the Hospital or a Member to preserve the life of the patient or to prevent an impairment of the patient's health and it is not possible to obtain the patient's or the patient's representative's consent, the required procedure, treatment, examination or test may be performed without consent. The Member shall document in the medical record the reasons for proceeding with the procedure, treatment, examination or test without consent.

7. Telephone Consent. Any consent may be obtained by telephone, if such consent is documented and signed by two (2) witnesses to the conversation.

8. Refusal of Consent. As a general principle, any competent adult may consent to or refuse any and all medical treatment for himself or herself even when such refusal may result in death. Neither the Hospital nor any Member is empowered

to impose medical treatment on a competent adult who refuses such treatment, absent a court order to the contrary.

9. Living Wills. A competent adult patient may execute a document known as "living will" specifying conditions under which he/she requests his/her Member to terminate treatment, including termination of life-support systems. Similarly, a competent adult may execute a document known as "life prolonging procedures will declaration," which sets forth his/her request for life-support measures to be continued as long as possible. Such documents are set out in the Indiana Living Will Statute, and any patient presenting such a document should be referred to the medical social services department to verify the form and content of the document and to advise the attending Member of the procedures required for honoring such a document.

10. Termination of Life Support. Any Member considering termination of life-support systems for a terminally-ill patient who has not executed a living will may consult the Hospital administration for legal advice.

11. Compliance with Living Wills. A Member shall comply with living wills and other types of advance directives to the fullest extent possible, consistent with reasonable medical practice. If unwilling to comply, the Member must notify the patient or the patient's representative when the declaration is delivered or as soon thereafter as possible, and must document such notification in the patient's medical record. If the Member fails to notify the patient of unwillingness to comply and the patient later becomes incompetent, the Member must promptly take all reasonable steps to transfer care of the patient to a Member who is willing to comply with the wishes of the patient.

12. Organ Donation. Indiana law requires the Hospital and Physicians to notify next-of-kin of potential organ donors of the availability of the organ donor programs. Any person who has signed an organ donor card (frequently found on the back of driver's licenses) has authorized donation of his/her body parts. Any Physician who has a patient who may be a potential organ donor should contact medical social services to discuss their duties to discuss organ donor programs with the patient's family.

N. DO NOT RESUSCITATE

1. Definition. "Do Not Resuscitate Order" or "DNR Order" shall mean the following: In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitative measures will be initiated.

2. Guidelines:

a. A comprehensive evaluation of the patient's medical condition is necessary before issuing a DNR Order.

b. The attending Physician, in consultation with the competent patient, or if the patient is incompetent, in consultation with the patient's representative and/or the patient's family, if any, shall determine the appropriateness of

the DNR Order for an individual patient. If a competent patient disagrees with a DNR Order or, in the case of an incompetent patient, the patient's representative or family members disagree with such order, a DNR Order shall not be implemented.

c. The Physician's Do Not Resuscitate Order need not be confirmed by a second Physician or an ethics committee. However, if the Physician has any substantial doubt about issue such an order, he or she is advised to obtain the opinion of another Physician.

d. DNR Orders are compatible with maximal therapeutic care. The patient may be receiving vigorous medical support and yet be appropriately considered for the DNR Order.

3. Procedures:

a. Once the decision has been made to issue a DNR Order, a "Patient Wishes and Rights Statement with Physician Orders" sheet shall be utilized.

b. A progress note should be written which includes the Physician's opinion of the patient's competence, Physician's opinion that the patient meets the medical criteria for a DNR Order, and the nature of the discussion with the patient, patient's representative and/or family.

c. The DNR Order may be rescinded at any time at the request of the patient or, if the patient was incompetent at the time the initial order was issued, by the patient representative. Such rescission shall be recorded in the Physician's orders and authenticated with signature, time, and date.

O. CME RULE

1. Requirements. All Members of the Medical Staff are required to accrue a minimum of fifty (50) hours of Category I continuing medical education in a two (2) year application/reapplication cycle, and Members with delineated clinical privileges at the Hospital are required to complete a minimum of fifty percent (50%) of those hours in continuing education that is directly related to the privileges granted. Each Member shall document accrued continuing medical education activities biyearly (every two years) in conjunction with the reapplication and re-credentialing process. Allied Health Professionals are required to complete such continuing professional education to satisfy the Indiana licensing requirements for their profession.

2. Noncompliance. Failure of the Member to document compliance with continuing medical or professional education requirements will result in a limited probationary reappointment of one (1) year. If continuing medical or professional education requirements are not met by the end of the probationary year, the Member or Allied Health Professional will be considered to have resigned from the Medical Staff of the Hospital or to have resigned his or her Clinical Privileges, as applicable. This automatic termination will not give rise to hearing and appeal rights granted in the Bylaws.

P. NOTIFICATION REQUIREMENTS:

1. Letters of Notification. All Members and Allied Health Professionals shall promptly report the following to the Medical Staff office:

   a. Any disciplinary action taken or proposed to be taken against the Member or AHP by a State licensing authority;

   b. Any disciplinary action proposed or taken against Member or AHP by a health care organization (other than the Hospital) at which the Member or AHP has clinical privileges;

   c. The filing of any law suit against the Member or AHP alleging malpractice;

   d. Any indictment, guilty plea, or judicial finding of guilt involving a felony, misdemeanor committed in the course of the practice of the Member's or AHP's profession, or misdemeanor involving moral turpitude;

   e. Any "quality letter" from a Peer Review organization or its equivalent. The Member or AHP shall submit a copy of the "quality letter" to the Medical Staff office within twenty-four (24) hours of receipt along with a letter of notification.

2. Confidentiality. A letter of notification shall only be used in the Hospital as part of the Peer Review, utilization review, and quality assurance process and shall not be released to third parties unless required or permitted by law or authorized by the Member or AHP.

3. Forward to Committee. A copy of each letter of notification shall automatically be forwarded to the Chairman of the appropriate Medical Staff committee for appropriate action.

4. Failure to Comply. Failure to comply with the provisions of this Section P may result in disciplinary action.

Q. REGULATORY REQUIREMENTS:

As a condition for obtaining or continuing Clinical Privileges, all Members and Allied Health Professionals agree to perform any and all services in conformance with all State and Federal statutes, regulations, regulatory requirements and applicable accreditation standards