MEDICAL STAFF BYLAWS
OF
FAIRBANKS HOSPITAL INC.

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PREAMBLE

These Bylaws, which originate with the Medical Staff, are adopted to organize the Medical Staff of Fairbanks Hospital, Inc. ("Hospital") and to provide a framework for self-governance in order to permit the Medical Staff to discharge its responsibilities in matters involving the clinical work and quality of medical care provided to patients, and to govern the orderly resolution of these purposes. These Bylaws provide the professional and legal structure for the Medical Staff to fulfill its obligations to the Governing Body. These Bylaws, when adopted by the Medical Staff and approved by the Governing Body, create a system of mutual rights and responsibilities between Members of the Medical Staff and the Hospital, however, these Bylaws are not intended to be a contract.

ARTICLE 1 - MEDICAL STAFF BYLAWS

Section 1.1. Name. The Medical Staff consists of Members who provide services in the Hospital, which is licensed and accredited. These bylaws shall be the Bylaws of the Medical Staff of Fairbanks Hospital, Inc. and shall apply to all Members of the Medical Staff and as applicable to any practitioner granted clinical privileges to practice in the Hospital. The Policies enacted pursuant to these Bylaws apply to all Members and, as applicable, to any practitioner granted clinical privileges to practice in the Hospital. These Bylaws and Policies and those of the Governing Body are compatible and should be read as a cohesive document.

Section 1.2. Purpose. The Medical Staff is organized to carry out its responsibilities to the Governing Body, including to strive for excellence in patient care and community health. The Medical Staff is accountable to the Governing Body for the quality of the medical care provided to the patients in the Hospital and accepts and discharges this responsibility as described in these Bylaws and Policies, subject to the ultimate authority of the Hospital's Governing Body.

Section 1.3. Effect. These Bylaws shall not be considered nor represent to be a contract between the Medical Staff and the Hospital. Appointment and continued membership or delineation of clinical privileges shall be based upon justification of current qualifications, professional conduct, and other requirements stated herein.

Section 1.4. Governing Law. These Bylaws and Policies as they relate to peer review activities shall be governed by and construed in accordance with the Health Care Quality Improvement Act of 1986 and the Indiana Peer Review Statute, and to the extent not so governed, by the other laws of the state of Indiana. The Medical Staff is considered part of an organized health care arrangement ("OHCA") as defined in the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 with Community Health Network, Inc. If an Applicant is not already a participant in the Network OHCA, the Applicant shall become part of the Network OHCA upon appointment.

ARTICLE 2 - DEFINED TERMS

Section 2.1. Usage. The Medical Staff Bylaws, Rules and Regulations, and Policies shall be interpreted using these defined terms unless stated otherwise.

"Accreditation Body" means any organization which (1) awards an accreditation or certification to or sought by the Hospital to obtain reimbursement or improve quality; or (2) provides quality oversight programs to the Hospital.

"Administration" means those individuals, including product or service line directors acting on behalf of the Governing Body in the overall management of the Hospital, or specific area of service and includes the Administrator.

"Administrator" means the person appointed by the Governing Body who supervises the overall day to day operation of the Hospital, whatever the title, such as Hospital president, executive, or chief executive officer and whenever unavailable includes the Administrator's designee.

"Advance Practice Nurse" means a nurse practitioner or clinical nurse specialist who currently holds a valid license to practice nursing in the State of Indiana and has matriculated from a graduate program offered by an accredited college or university which prepares registered nurses to practice as a nurse practitioner or clinical nurse specialist.

"Adverse Action" means a professional review action as defined by the Health Care Quality Improvement Act ("HCQIA"), that if approved by the Governing Body of the Hospital, will Adversely Affect the clinical privileges or membership of a Privileged Practitioner for a period of greater than thirty (30) days.

"Adversely Affect" means reduce, restrict, suspend, revoke, deny or fail to renew clinical privileges or membership.

"Affected Practitioner" means the Member or Applicant against whom a proposed Adverse Action is pending.

"Allied Health Practitioner" means any Advance Practice Nurse or Physician Assistant, granted clinical privileges by the Governing Body and collectively are referred to as "Allied Health Practitioner Staff."

"Applicant" means a practitioner seeking Membership to the Medical Staff and/or clinical privileges and includes members and Privileged Practitioners.

"Application" means the form developed by Medical Executive Committee and all supporting documentation required to apply for Medical Staff Membership and/or clinical privileges.

"Approved Residency Program" means a post-graduate training program approved by the Accreditation Committee for Graduate Medical Education, the American Osteopathic Association, the Council of Podiatric Medical Education, or the American Dental Association.

"Board Certification" means the board certification approved by the Medical Executive Committee as referenced in the applicable core privilege form for which an Applicant or Member seeks clinical privileges.

"Board Eligible" means that the Applicant or Member has completed an Approved Residency Program and is eligible for board certification and actively participating in the exam process leading to certification and has not exhausted all attempts or time limits.

"Bylaws" means the Medical Staff Bylaws of Fairbanks Hospital, Inc.

"Credentialing Representative" is any individual assisting the Medical Executive Committee of the Medical Staff in credentialing and other Peer Review processes. Such individual is Personnel of the Peer Review Committee.

"Disaster" means an emergency that due to its complexities, scope, or duration, threatens the Hospital's capabilities and requires outside assistance to sustain patient care, safety, or security functions.

"Encounter" means a patient contact requiring a history and physical exam or other patient assessment and includes inpatient admissions, patient observations, inpatient consultations, surgeries, or procedures requiring a history and physical exam or other assessment.

"Final Adverse Action" means an Adverse Action taken by the Governing Body after all professional review activity within these Bylaws and Policies have been exhausted or waived. Such action shall be reported to the National Practitioner Data Bank if the action lasts over thirty (30) days and was based on the professional competence, behavior or conduct of the Affected Practitioner.

"Governing Body" means the board of directors of Fairbanks Hospital or delegated Governing Body committee.

"Healthcare Entity" means a hospital, surgery center, or other entity that provides healthcare services and follows a formal peer review process for the purpose of furthering quality health care.

"Hospital" means Community Fairbanks Recovery Center.

"Indiana Medical Malpractice Act" means Title 34, Article 18, or any successor legislation.

"Indiana Peer Review Statute" means Title 34, Article 30, or any successor legislation.

"Medical Director" means the physician appointed by the Governing Body to oversee the clinical operations of the Hospital and serves as the President of the Medical Staff of the Hospital and whenever unavailable includes the Medical Director's designee.

"Medical Executive Committee" means the committee of the Medical Staff which shall constitute the governing body of the Medical Staff as described in these Bylaws and Policies.

"Medical Staff" or **"Staff"** means the formal organization of all Physicians who are granted Membership, under these Bylaws and Policies.

"Medical Staff Year" means the period from April 1 to March 30.

"Member" means a Physician who has been granted Membership on the Medical Staff of the Hospital pursuant to the terms of these Bylaws and Policies.

"Network" means Community Health Network, Inc.

"Network Executive" means a senior leader within the Network with administrative responsibilities to the Hospital and Medical Staff.

"Peer Review" has the same definition set forth in Title 34, or any successor legislation and includes evaluating the: (1) qualifications of professional health care providers; (2) patient care rendered by professional health care providers; or (3) merits of a complaint against a professional health care provider that includes a determination or recommendation concerning the complaint, and the complaint is based on the competence or professional conduct of an individual health care provider, whose competency or conduct affects or could affect adversely the health or welfare of a patient or patients.

"Peer Review Committee" has the same definition set forth in Title 34, or any successor legislation and includes the Governing Body, including its delegated committees with Peer Review responsibilities, or any Hospital or Medical Staff committee conducting Peer Review.

"Personnel of Peer Review Committee" has the same definition set forth in Title 34, or any successor legislation and includes members of the committee and any individuals who assist the Peer Review Committee in any capacity including employees, representatives, agents, attorneys, investigators, experts, assistants, clerks, staff and any other person or organization.

"Physician" means an individual who currently holds a valid license to practice medicine or osteopathic medicine in the State of Indiana.

"Physician Assistant" means an individual who currently holds a valid physician assistant license in the State of Indiana, maintains certification by the National Commission on Certification of Physician Assistants, and is supervised by a physician Member.

"Policies" means the Rules and Regulations and Policies of the Medical Staff.

"President" or **"Medical Staff President"** means the Medical Director of the Hospital.

"Privileged Practitioner" means any practitioner, including a Member to whom the Governing Body has granted permission to render specific designated services in the Hospital, referred to as clinical privileges, through the Medical Staff or equivalent process approved by the Medical Executive Committee and Governing Body of the Hospital.

"Qualified Provider" means a practitioner who has sufficient professional liability insurance because the practitioner either (1) meets the requirements of the Indiana Medical Malpractice Statute including paying the surcharge; or (2) has insurance coverage under the Federal Tort Claim Act.

ARTICLE 3 - MEMBERSHIP

Section 3.1. Nature. Membership is a privilege which shall be granted by the Governing Body only after an Applicant demonstrates that the qualifications for membership have been met and the responsibilities of membership as set forth in Article 4 have been accepted. Membership shall confer only such prerogatives as have been established in these Bylaws.

Section 3.2. Threshold Eligibility Criteria. Before appointment and continuously thereafter including at reappointment, the Applicant must demonstrate each of the following criteria:

(a) current, unrestricted valid license to practice medicine in Indiana;

(b) never had a license to practice revoked or suspended by any state licensing agency;

(c) where applicable to their practice, a current unrestricted state and federal controlled substance registration;

(d) availability on a continuous basis, either personally or by arranging appropriate coverage, to (i) respond to the needs of their practice patients admitted to the Hospital and (ii) respond to emergency department patients during those times when they are on call for the emergency department in a prompt, efficient, and conscientious manner as defined by the Medical Executive Committee and Governing Body. "Appropriate coverage" means coverage by another Member with appropriate specialty-specific privileges as determined by the Medical Executive Committee.

(e) agree to personally fulfill all responsibilities regarding emergency service call coverage for their specialty or to obtain appropriate coverage as determined by the applicable department or Medical Executive Committee with other Members for those times when the Applicant will be unavailable;

(f) Qualified Provider. The Governing Body may approve an initial Applicant or Privileged Practitioner upon becoming a Qualified Provider with sufficient evidence from the professional malpractice carrier that the surcharge will be paid and policy effective prior to the commencement of any services in the Hospital.

(g) no convictions of, or plea of guilty or no contest to, any fraud or abuse related to Medicare, Medicaid, or other federal or state governmental or private third-party payer, nor history of any civil monetary penalties;

(h) no convictions of, or plea of guilty or no contest to any felony, or any misdemeanor relating to controlled substances, moral turpitude, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence;

(i) no current or history of exclusion, preclusion, or debarment from participation in Medicare, Medicaid, or other federal or state governmental health care programs;

(j) no current or history of medical staff appointment or clinical privileges denied, revoked, or terminated by any Healthcare Entity or health plan for reasons related to clinical competence or professional conduct;

(k) no history of resignation from medical staff appointment or relinquishment of clinical privileges during an investigation or in exchange for not conducting such an investigation;

(l) recent clinical activity in their primary area of practice in an acute care setting or residency program during the last two years;

(m) agree to satisfy any current or future eligibility requirements for the clinical privileges sought;

(n) if applying for clinical privileges in an area covered by an exclusive contract, meet the specific requirements set forth in such contract;

(o) compliance with all applicable training and educational protocols that may be adopted by the Network and Medical Executive Committee, including those

involving electronic medical records, computerized physician order entry, the privacy and security of protected health information, infection control, and culture of safety;

(p) agree to utilize the Network's electronic mail system for the receipt of notifications and notices under these Bylaws, and to monitor the emails on an ongoing basis for announcements from the Network, Hospital, and Medical Executive Committee. If using a personal email system, agree to utilize the Network's encrypted email services by signing into the Network and setting up a password to communicate information under the Bylaws or to share protected health information;

(q) compliance with any health screening requirements such as tuberculosis testing, mandatory vaccines, and infectious agent exposures;

(r) successful completion of an Approved Residency Program as set forth in the applicable clinical privilege forms. The Approved Residency Program requirement shall not apply to any Member who was continuously appointed prior to [insert date Bylaws approved by Governing Body]. Such Member shall be grandfathered and shall be governed by the Approved Residency Program requirement, if any, in effect at the time of their initial appointment.

(s) Board Eligible, Board Certified, or maintenance of Board Certification, whichever is applicable. The requirements pertaining to Board Eligible, Board Certification, or maintenance of Board Certification shall not apply to any Member who was continuously appointed prior to **[Insert date Bylaws approved by the Governing Body]**. Such Member shall be grandfathered and shall be governed by the Board Eligible, Board Certification, and maintenance of Board Certification requirements, if any, in effect at the time of their initial appointment.

The criteria identified in Section 3.2(a)-(s) are referred to as the "Threshold Eligibility Criteria."

Section 3.3. Exceptions and Waiver Requests. Only the Governing Body may waive a Threshold Eligibility Criteria for membership or clinical privileges or both upon recommendation of the Medical Executive Committee. Any Applicant who does not satisfy one or more of the Threshold Eligibility Criteria may request a waiver. A Member who, between credentialing cycles, and for administrative or other reasons not related to professional competence or professional conduct may also request a waiver. Such request must be submitted to the Medical Staff Office to be resolved prior to processing of the reapplication for membership and clinical privileges, or prior to the lifting of an automatic suspension. The Medical Executive Committee will consider the request and make a recommendation to the Governing Body for its decision prior to processing the reapplication. The waiver will be approved or denied by the Governing Body within a reasonable timeframe not to exceed sixty (60) days.

Section 3.4. Effect of Other Affiliations. No person shall be entitled to membership on the Medical Staff merely because the person holds a certain degree, a license to practice in this State, membership in any professional organization, any board certification, or presently holds membership and privileges at another Healthcare Entity. No practitioner including those in a medical administrative position by virtue of employment or contract with the Network or Hospital shall provide services to patients of this Hospital unless clinical privileges have been granted in accordance with these Bylaws.

Section 3.5. Non-Discrimination. No aspect of medical staff membership or clinical privileges shall be denied based on sex, race, age, creed, color, national origin, sexual orientation, or any disability that does not adversely jeopardize patient safety.

Section 3.6. Term. All initial appointments to the Medical Staff in any category shall be for a period not to exceed two (2) years. Reappointments shall be for a period of not more than two (2) years unless the Medical Executive Committee recommends, and Governing Body approves that the Member should be re-evaluated sooner.

ARTICLE 4 - RESPONSIBILITIES AND RIGHTS

Section 4.1. Responsibilities. Unless provided otherwise in these Bylaws, these responsibilities apply to Members assigned to the Active Staff or Courtesy Staff.

(a) Each Member shall provide patients with the quality of care that meets the professional standards of the Medical Staff.

(b) Each Member shall provide continuous coverage for patients and appropriate coverage during periods of absence.

(c) Each Member shall participate in emergency department and inpatient emergency coverage.

(d) Each Member shall prepare and complete medical records in a timely manner. A physical examination and medical history must be conducted and documented within 24 hours after admission, when applicable. When a history and physical examination performed within 30 days prior to an admission exists, it must be updated within 24 hours of admission after assessing the patient by noting any changes in the patient's condition.

(e) Each Member shall use reasonable means to secure authorization to perform autopsies in cases of unusual deaths and complete death certificates as applicable.

(f) Each Member shall discharge in a responsible and cooperative manner assignments as imposed by virtue of Medical Staff membership, including committee assignments.

(g) Each Member shall work cooperatively with others so as not to undermine the culture of quality improvement and safety.

(h) Each Member shall participate in continuing education programs as determined by the Medical Staff.

(i) Each Member shall refuse to engage in improper inducement for patient referrals.

(j) Each Member shall appear for personal interviews whenever requested by a Medical Staff committee.

(k) Each Member shall respond in a timely manner to performance improvement activities of the Medical Staff.

(l) Each Member shall utilize the limited resources of the Hospital in an efficient manner.

(m) Each Member shall provide data related to indications and outcomes, as required by any Accreditation Body upon request by the Hospital as a condition of the continued ability to exercise clinical privileges.

(n) Each Member shall conduct themselves to reflect favorably on the Medical Staff. Physician Members shall follow the principles of ethics adopted by the American Medical Association and the certifying board referenced in the applicable core privilege form. Non-Physician Members shall follow the principles of ethics of the certifying board referenced in the applicable core privilege form.

(o) Each Member shall abide by the Medical Staff Bylaws, Policies, Rights and Expectations Acknowledgement, and applicable Hospital and Network policies.

(p) Each Member shall abide by all applicable federal, state, and local law and Accreditation Body regulations.

(q) Each Member shall discharge such other Medical Staff obligations as may be established from time to time by the Governing Body.

Section 4.2. Rights. Unless provided otherwise in these Bylaws, these rights or prerogatives only apply to Members assigned to the Active Staff or Courtesy Staff.

(a) Members are entitled to provide services in a culture that embraces quality improvement and safety.

(b) Members are entitled to be notified of the performance standards and expectations, how those will be measured, and periodic feedback on personal performance.

(c) Unless necessary to protect patient safety or prevent disruption to the operation of the Hospital, the Member will be notified after a formal investigation is initiated by the Medical Executive Committee on any matter of performance or conduct which could result in proposed Adverse Action.

(d) Members subject to a proposed Adverse Action have the right to a hearing and appeal, unless excluded or waived under these Bylaws.

(e) Members are entitled to be present at any Medical Staff committee meeting except during portions involving Peer Review.

(f) Members are entitled to meet with the Medical Executive Committee on matters relevant to the responsibilities of the Medical Executive Committee or whenever unable to resolve a matter of concern after discussion with the appropriate committee chair.

(g) Members are entitled to be informed of Medical Staff information and developments. Changes to Policies will be distributed in a timely manner. Proposed bylaw amendments will be sent electronically thirty (30) days in advance of the meeting at which the vote is taken.

(h) Each Member shall be allowed an opportunity to review their credentials or quality file related to the Member's personal practice as set forth in these Bylaws and Policies.

(i) Matters undertaken in the performance of Medical Staff duties discussed in committee deemed to be confidential and otherwise privileged shall remain confidential.

(j) Any Member eligible to vote has the right to initiate a recall vote of any Medical Staff officer, in accordance with the recall provisions provided in these Bylaws.

(k) Any Active Staff Member may call for a general medical staff meeting in accordance with the meeting provisions provided in these Bylaws.

Section 4.3. Exclusions. These rights do not pertain to Peer Review activities involving an individual Member. Recourse for such matters is provided to the individual Member as described herein.

Section 4.4. Conflict of Interest. In any instance where any Medical Staff officer, or member of any Medical Staff committee has or reasonably could be perceived to have a conflict of interest or to be biased in any matter involving another Medical Staff Member that comes before such individual or Medical Staff committee, or in any instance where any such Member or committee member brought the complaint against the Member, such individual or committee member shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time though the individual or committee member may be asked and may answer any questions concerning the matter before leaving. As a matter of procedure, the committee chair designated to make such a review should inquire, prior to any discussion of the matter, whether any committee member has any conflict of interest or bias. The existence of a potential conflict of interest or bias on the part of any committee member may be called to the attention of the chair by any committee member with knowledge of the matter.

The Medical Director shall have a duty to delegate review of an application for appointment, reappointment, or clinical privileges or questions that may arise to another member of the Medical Staff if the Medical Director has a conflict of interest with the Member under review or could be reasonably perceived to be biased.

In any instance where a Member of the Medical Staff has or reasonably could be perceived to have a contractual relationship which creates a conflict of interest in the delivery of quality patient care, that issue may be reviewed by the Medical Executive Committee for recommendation and clarification. If unresolved at that level, the issue should be directed to the Governing Body for resolution upon recommendation of the Medical Executive Committee.

All members of the Medical Executive Committee are required to execute the Hospital's Corporate Conflict of Interest Statement annually.

ARTICLE 5 - CATEGORIES

Section 5.1. Categories. Active Staff and Courtesy Staff are the two (2) categories of Membership on the Medical Staff. Category status will be determined by the Governing Body based on the recommendations of the Medical Executive Committee at each appointment. Only Members appointed to the Active Staff or Courtesy Staff are eligible for clinical privileges. Unless provided otherwise in these Bylaws, only Members appointed to Active Staff are eligible to vote and hold office.

Section 5.2. Active Staff.

5.2.1. Qualifications. The Active Staff category shall consist of Members who meet the qualifications and have met all requirements set forth in Article 3;

(a) Are regularly involved in caring for patients in the Hospital and who have a genuine concern and interest in the Hospital and;

(b) attend Medical Staff meetings.

5.2.2. Prerogatives. In addition to the prerogatives set forth in Article 4, the Active Staff Member shall have the following prerogatives:

(a) exercise clinical privileges granted by the Governing Board;

(b) vote on all matters presented at general and special meetings of the Medical Staff and committees to which the Member is appointed; and vote to limit or expand the powers of the Medical Executive Committee;

(c) be eligible to hold office and sit on or act as chair of any committee unless otherwise specified;

(d) attend any educational programs presented by the Medical Staff and Hospital;

(e) attend open meetings of Medical Staff committees, without vote;

(f) may call for a general medical staff meeting in accordance with the meeting provisions period.

5.2.3. Responsibilities. In addition to the Responsibilities set forth in Article 4, the Active Staff member must:

(a) Contribute to the organization and administrative affairs of the Medical Staff;

(b) Participate in providing emergency call for individuals with no stated physician relationship with an existing Member and in other appropriate coverage arrangements as adopted by the Medical Executive Committee and the Governing Body;

(c) perform such further duties as may be required under the Bylaws and Policies, including any future amendments;

(d) attend not less than 50% of Medical Staff meetings on an annual basis.

Section 5.3. Courtesy Staff.

5.3.1. Qualifications. The Courtesy Staff category shall consist of Members who meet the qualifications set forth in Article 3.2 and provide expertise in a specialty

which is needed in the Hospital but no otherwise available from Active Staff members.

5.3.2. Prerogatives. In addition to the prerogatives set forth in Article 4, the Courtesy Staff Member shall have the following prerogatives to:

(a) vote on Medical Staff matters;

(b) hold office; and

(c) serve as voting member on Medical Staff.

5.3.3. Responsibilities. In addition to the responsibilities set forth in Article 4, the Courtesy Staff must:

(a) contribute to the organizational and administrative affairs of the Medical Staff;

(b) be allowed to participate in providing emergency call for individuals with no stated physician relationship with an existing Member and other coverage arrangements as defined in department policies adopted by the Medical Executive Committee and the Governing Body;

(c) perform such further duties as may be required under these Bylaws and Policies, including any future amendments to these documents;

(d) attend no less than 50% of the medical staff meetings on an annual basis.

Section 5.4. Limitation of Prerogatives. The prerogatives set forth under each appointment category are general in nature and may be subject to limitations by special conditions attached to a particular appointment, by other sections of these Bylaws and Policies.

Section 5.5. Assignment to Staff Categories. Each Member granted clinical privileges shall be assigned either to the Active Staff or Courtesy Staff category of membership.

Section 5.6. Category Change. Requests may be made for a change in Medical Staff category status once per year. Such requests shall be in writing and made to the Medical Executive Committee for recommendation to the Governing Body for final action.

ARTICLE 6 - APPOINTMENT

Section 6.1. Appointment and Reappointment. Appointments to the Medical Staff shall be made by the Governing Body upon the recommendations of the Medical Executive Committee.

Section 6.2. Initial Appointment. The initial Application form shall be developed by the Medical Executive Committee and ratified by the Governing Body. The form shall require detailed information which shall include, but not be limited to, information concerning:

(a) the Threshold Eligibility Criteria and additional requirements for the various Membership categories; at least three (3) peer references who have had extensive experience in observing and working with the Applicant in the last year and who can provide adequate reference information concerning the Applicant's professional competence, professional conduct, and ethical character;

(b) the requested membership category, and clinical privileges, if any; and

(c) an official identification for verification of identity.

6.2.1. Initial Application Fee. A non-refundable fee, in an amount established by the Medical Executive Committee and ratified by the Governing Body, shall be received from the Applicant at the time of an initial Application.

6.2.2. Threshold Eligibility Criteria. Individuals interested in appointment to the Medical Staff will be given access to the Threshold Eligibility Criteria and additional eligibility requirements of the membership categories before the Application form and further information is provided. After reviewing the threshold eligibility criteria and additional eligibility requirements of the membership categories, individuals who believe that they will satisfy these requirements may request the Application form. Such individuals will be given access to Application form, the Medical Staff Bylaws and Policies, and applicable Hospital and Network policies.

6.2.3. Effect of Application. By applying for appointment, reappointment, or clinical privileges, each Applicant:

(a) Agrees to appear for personal interviews at any reasonable time as requested by a Credentialing Representative;

(b) Authorizes Credentialing Representatives to solicit and act upon information, including otherwise privileged or confidential information, provided by third parties bearing on the Applicant's credentials and agrees that any information so provided shall not be required to be disclosed to him or her if the third party providing such information does so on the conditions that it be kept confidential;

(c) Authorizes third parties to release information, including otherwise privileged or confidential information, as well as reports, records, statements, recommendations, and other documents in their possession, bearing on his or her credentials to any Credentialing Representative, and consents to the inspection and procurement of such information, records, and other documents by the Credentialing Representative;

(d) Authorizes the Credentialing Representatives to release information about such individual to other health care entities and their agents, who solicit such information for the purpose of evaluating the Applicant's professional qualifications pursuant to the Applicant's request for appointment, reappointment, or clinical privileges;

(e) Authorizes the Network or Hospital to maintain information concerning the Applicant's age, training, board certification, licensure, and other privileged or confidential information in a centralized physician data base for the purpose of making aggregate physician information available for use by the hospitals within the Network;

(f) Authorizes the Network or Hospital for peer review purposes to release information, including otherwise privileged or confidential information, including but not limited to quality assurance information, obtained from or about the Applicant to peer review committees of the affiliated hospitals and facilities within the Network, including Community Physicians Network when the Applicant is or will be a Network employee;

(g) Releases from any liability all persons for their acts performed in connection with investigating and evaluating the Applicant;

(h) Releases from any liability to the fullest extent permitted by law, all individuals and organizations who provide information, including otherwise privileged or confidential information, regarding the Applicant to the Network or its affiliated hospitals concerning the Applicant's credentials including performance of patient care and complaints related to competence and behavior unless such information is false and the third party providing the information knew it was false;

(i) Authorizes a criminal background check;

(j) Consents to the disclosure to other hospitals, and licensing boards and other similar organizations any information including otherwise privileged or confidential information regarding the Applicant's competence, professional or ethical standing that the Network or Hospital may have and releases Network and Hospital from liability for so doing, to the fullest extent permitted by law;

(k) Pledges to provide for continuous quality care for the Applicant's patients;

(l) Agrees to comply with the Network's Responsibility and Compliance Program, and applicable Codes of Conduct of the Medical Staff, Hospital, and Network;

(m) Agrees that the Network's affiliated hospitals and other facilities, through their peer review structures, may share information, including otherwise privileged or confidential information, concerning the Applicant's ongoing eligibility for membership and clinical privileges. Such information may include interpersonal and communication skills; professionalism including character and ethics; the ability to continuously learn, improve, and work harmoniously with others; the evaluation of patient care rendered including the accuracy of diagnosis, the propriety, appropriateness, quality or necessity of care rendered; utilization of services, procedures, and facilities in the treatment of patients; incident reports, complaints, or concerns about the Applicant; any performance improvement activities such as external reviews, focused professional practice evaluation, and ongoing professional practice evaluation; and fitness for duty evaluations;

(n) Acknowledges that the Applicant (a) has received and read the Bylaws and Policies of the Medical Staff; (b) agrees to be bound by the terms thereof if the Applicant is granted membership and/or clinical privileges; and (c) agrees to be bound by the terms thereof without regard as to whether or not the Applicant is granted membership and/or clinical privileges in all matters relating to consideration of this Application;

(o) Agrees that the foregoing provisions are in addition to any agreements, understandings, waivers, authorizations, or releases provided by law or contained in any application or request forms.

6.2.4. Burden of Producing Information and Resolving Reasonable Doubt. In connection with any Application, the Applicant shall have the burden of producing information for adequate evaluation of the Applicant's qualifications and suitability for the requested membership category and clinical privileges, including resolving any reasonable doubts about these matters and satisfying requests for information. The Applicant's failure to sustain this burden shall be deemed a termination of the Application process after thirty (30) days without a satisfactory response. This burden may include submission to a health status assessment at the Applicant's expense if deemed appropriate and in accordance with Medical Staff Wellness, Fitness, and Impairment Policy. Health status assessments for initial Applicants will only be performed after a conditional offer of clinical privileges has been made.

6.2.5. Appointment Process for Initial Appointment. The Medical Staff shall evaluate each Application for appointment through its designated committees and shall make recommendations to the Governing Body. The following steps describe the process of evaluating appointment Applications for Medical Staff Membership. Each Application for appointment to the Medical Staff shall be submitted in writing or electronically on the prescribed Application form with manual or approved electronic signature by the Applicant. An Application for initial appointment will

not be reviewed until all questions appear to be answered, all requested documents and explanations provided.

(a) Medical Staff Review and Verification. The Applicant shall sign the Application and verify that all answers and provided information are true and accurate. The Applicant shall acknowledge that if it is discovered, at any time, that false information was submitted or material information was omitted, the Applicant shall be subject to immediate termination with no right to a hearing or appeal. Once all Application questions appear to be answered and all requested information provided and fee paid, the information presented in and with the Application will be reviewed to ensure that the Applicant appears to meet the Threshold Eligibility Criteria before the Application is processed. If the Application shows the Applicant does not meet the Threshold Eligibility Criteria, then the Applicant is not eligible for membership. The Applicant will be notified, and no further action will occur regarding the Application. If the Application shows that the Applicant may be eligible for membership, the Credentialing Representative, working on behalf of the Medical Executive Committee, will complete the primary source verification of information submitted on the Application. If the information cannot be verified or any of the peer references or Healthcare Entities or providers do not respond, the Applicant will be notified, and no further action will occur regarding the Application. After collecting references and verifying responses, the Application and all supporting materials shall be transmitted to the Medical Director. Any inconsistent information discovered during the verification process will be flagged for the Medical Director's Review.

(b) Medical Director Review. The Medical Director shall evaluate the credentials of the Applicant within a reasonable time and attempt to resolve any inconsistent information flagged. The applicable Medical Director shall examine the character, clinical competence, professional qualifications, and ethical standing of the Applicant and shall determine through the Application information and from the references and other available resources, whether the Applicant satisfies the Threshold Eligibility Criteria and requested membership category qualifications. For those Applicants seeking clinical privileges, the Medical Director shall evaluate whether the Applicant meets the qualifications for all clinical privileges requested based on the criteria set forth in the applicable clinical privileges' forms. The Medical Director may request additional evidence from the Applicant of the Applicant's ability to perform certain clinical privileges. The Application shall not be deemed complete until such information is produced. Thereafter, the Medical Director shall make a written report of the evaluation for

presentation to the Medical Executive Committee, and report any inconsistent information identified and whether it has been addressed with the Applicant and if so, how it was resolved. The Medical Director recommends that the Applicant either be accepted or rejected for membership, or that the Application be deferred for further consideration. For Applicants seeking membership to the Active or Courtesy Staff, the recommendation shall contain recommendations concerning all clinical privileges requested and when warranted any proctoring or limitation recommendations. The applicable Medical Director may designate another Member of the Medical Staff to assist in the review set forth in this provision.

(c) Medical Executive Committee Review. At the next regular Medical Executive Committee meeting following receipt of the Medical Directors recommendation, the Medical Executive Committee shall review the recommendation, discuss any resolved reasonable doubt or inconsistent information, and determine whether any additional information is needed to make an informed recommendation on the Applicant. If any reasonable doubt by the Medical Executive Committee exists concerning the Applicant's qualifications, the Application shall be deemed incomplete and a decision on the Application tabled until the Applicant has been given an opportunity to resolve such doubt or withdraw the Application. The Medical Executive Committee may refer an Application back to the Medical Director if it reasonably believes the Application is incomplete. Whenever the Application is incomplete, the Application will be deemed automatically withdrawn if it remains incomplete after sixty (60) days. The Medical Executive Committee shall make a recommendation to the Governing Body only when all reasonable doubts have been resolved by the Applicant in the time frame set forth herein. The recommendation to the Governing Body will address membership category, and, if applicable, clinical privileges, and whenever warranted any conditions to those recommendations.

(d) Governing Body Review. When the recommendation of the Medical Executive Committee is favorable to the Applicant, the recommendation shall be promptly forwarded with any additional documentation to the Governing Body for action. The Governing Body will review the recommendation and determine whether to appoint the Applicant to the Medical Staff and authorize the Applicant to exercise clinical privileges subject to any additional conditions. Membership will be granted upon approval of the Governing Body. If the decision of the Governing Body Adversely Affects the Applicant, the Administrator shall notify the Applicant of such adverse decision as set forth in Section 10.5 and such decision shall be held in abeyance until the Applicant has exercised, waived, or has been deemed to have waived, his or her rights as provided in Section 10.6 of the Medical Staff Bylaws.

When the recommendation of the Medical Executive Committee is a proposed Adverse Action, the Medical Director shall notify the Applicant in accordance with Section 10.5. No proposed Adverse Action shall be forwarded to the Governing Body for action purposes until the Applicant has exercised, waived or has been deemed to have waived the Applicant's right to a hearing and appeal as provided in these Medical Staff Bylaws. At its regular meeting after all the Applicant's rights under the Medical Staff Bylaws have been exhausted or waived, the Governing Body shall act on the Application. The Governing Body's decision shall be the final action.

When the Governing Body's decision is final, the Governing Body shall send a notice of such decision to the Applicant and the Medical Executive Committee through the Administrator and make any reports as required by law.

Section 6.3. Reappointment. The reappointment Application form shall be developed by the Medical Executive Committee and ratified by the Governing Body. Members will be sent a reappointment Application to be completed sixty (60) days in advance of the appointment term expiration. The reappointment Application will not be processed until any outstanding fees or dues are paid in full. The Applicant's continued satisfaction of the Threshold Eligibility Criteria and additional requirements of requested membership category and clinical privileges will be verified. In addition, the Applicant's performance at the Hospital; compliance with Medical Staff Bylaws and Policies; cooperation with others in the Hospital; and appropriate use of Hospital facilities for the patients may be considered.

If the Applicant seeking renewal of clinical privileges has no or low volume, information from another accredited Healthcare Entity must be provided. Such Applicant seeking renewal shall provide case logs or other proof to the satisfaction of the Medical Executive Committee of current similar clinical activity from another accredited Healthcare Entity to demonstrate current competency. Such Privileged Practitioner will be under a focused professional performance evaluation whenever clinical privileges are exercised.

The process for evaluating reappointment Applications is the same process used on initial Applications. Additional information may be gathered from other peer review committees and evaluated by the Medical Director and Medical Executive Committee before making their recommendations to the Governing Body. If for any reason the term of the appointment shall expire prior to final action on the reapplication, the Medical Executive Committee may recommend that the Governing Body reappoint the Member with any conditions necessary for a period no greater than sixty (60) days. The Medical Executive Committee may, at its discretion, recommend more frequent reappointment intervals.

Section 6.4. Appointment Terms. Initial appointments and reappointments to the Medical Staff shall be for a period not to exceed two (2) years. Initial and subsequent authorization of clinical privileges shall be for a period not to exceed two (2) years during which time the Member may be subject to focused or ongoing professional practice evaluation. Appointments and reappointments of Applicants over the age of seventy (70) years of age shall be for a period of not more than one (1) year.

ARTICLE 7 - CLINICAL PRIVILEGES

Section 7.1. Delineation of Clinical Privileges. The Governing Body shall grant clinical privileges upon the recommendations of the Medical Director and the Medical Executive

Committee. Any Privileged Practitioner providing clinical services at the Hospital shall be entitled to exercise only those clinical privileges granted by the Governing Body. Such delineation shall confer on the Privileged Practitioner only such clinical privileges as specifically requested on the Application form and authorized by the Governing Body. All recommendations for appointment to Active and Courtesy Staff category must specifically recommend the clinical privileges to be granted, including any qualifying probationary condition relating to the exercise of the clinical privileges.

Section 7.2. Evaluation of Clinical Privileges Requests. Determination of clinical privileges shall be based upon the Threshold Eligibility Criteria used in evaluating Applicant's credentials for Medical Staff appointment, and the criteria set forth in the applicable clinical privilege forms. Clinical privilege determinations may also be based on pertinent information concerning the Applicant's clinical performance at other Healthcare Entities or settings including morbidity and mortality rates. The process for evaluating requests for clinical privileges is the same as for appointment. Following receipt of the request, the Medical Director shall consider such recommendation and make a recommendation to the Medical Executive Committee for consideration. The recommendation of the Medical Executive Committee concerning the clinical privileges request will be forwarded to the Governing Body. The steps described in the appointment process in Section 6.2.5. will be followed and associated details may be found in the Policies and the applicable clinical privilege forms.

Section 7.3. Additional Clinical Privileges Requests. Any Member may make a written request for modification of clinical privileges at any time but documentation of training and/or experience must support the request and the process for delineation of clinical privileges shall be followed.

Section 7.4. Professional Practice Evaluations. During the initial appointment period, the Member and any existing Member granted new clinical privileges shall be subject to focused professional practice evaluation (FPPE), which may include retrospective chart review, review of clinical practice patterns, simulation, close monitoring, proctoring, or supervision by the Medical Staff, external peer review, or discussion with individuals involved in the care of any patients. The Member may remain subject to FPPE until the Medical Executive Committee has recommended lifting the evaluation and the Governing Body concurs. In order for this to occur, the Medical Executive Committee must be given signed reports by t the proctor(s), if different, to which the Member was assigned, describing (a) the types and number of cases observed and the evaluation of the Member's performance; (b) a statement that the Member appears to meet all qualifications for unsupervised practice of the clinical privileges and has satisfactorily demonstrated the ability to exercise those clinical privileges granted. If any Member fails to satisfactorily perform during the FPPE period, those specific clinical privileges may be immediately terminated or limited. Upon such termination or limitation, the Member shall be entitled to a hearing, upon request, pursuant to these Bylaws. The Medical Staff also participates in ongoing professional practice evaluation ("OPPE') to identify practice outcomes and trends that impact the safety and quality of patient care by Privileged Practitioners. Information from the OPPE process will be used by leaders to determine if existing clinical privileges are maintained, revised, or revoked prior to or at the time of reappointment. The OPPE process is part of the Medical Staff's evaluation, measurement, and improvement of the current clinical competency of Privileged Practitioners.

Section 7.5. Reapplication After Denial. Any Applicant on initial Application denied Membership based on a falsification of information or a material omission in the Application shall be prohibited from applying for membership and clinical privileges for four (4) years. An initial Applicant who has otherwise been denied membership and clinical privileges on the Medical Staff by the Governing Body may not make further Application for membership for a period of two (2) years from the date of the Final Adverse Action. An Application for membership or request for clinical privileges received after that two (2) year period must include evidence demonstrating that grounds for the denial have been addressed. A Member who has been denied a request for additional clinical privileges shall not be eligible to request those additional clinical privileges until the Member can demonstrate additional training, education, and experience to support the request as set forth in the clinical privilege form and as deemed appropriate by the Medical Executive Committee. In all instances listed above, if such an Application is accepted as complete and the recommendation of the Medical Executive Committee is a proposed Adverse Action, the Applicant shall have hearing and appeal rights.

Section 7.6. Temporary Privileges.

7.6.1. Circumstances. A request for temporary privileges may be granted on a case-to-case basis: (i) fulfill an important patient care treatment, or services need such as the need for locum tenens; or (ii) an Applicant who has a completed Application, meets all requirements set forth below, has received approval by the Medical Director as described below, and is awaiting review by the Medical Executive Committee and the Governing Body.

7.6.2. Authority. Upon receipt of a completed Application from a qualified Applicant, the Administrator or designee may, upon the basis of information then available which may reasonably be relied upon as to the competence and professionalism of the Applicant, and written concurrence of the Medical Director, and the Hospital Administrator or their respective designees, grant temporary privileges.

7.6.3. Term. Temporary privileges will be in effect until the Governing Body takes final action on the Application, but not more than one hundred twenty (120) days.

7.6.4. Requirements. A request for temporary privileges shall be considered only upon verification of the following:

(a) A signed and completed Application for privileges.

(b) Current license to practice in the state of Indiana with no current or past successful challenges to licensure.

(c) Status as a Qualified Provider.

(d) Three (3) positive peer references who have had extensive experience observing and working with the Applicant.

(e) Competence to perform clinical privileges requested.

(f) No history of subjection to involuntary limitations, reduction, denial, or loss of clinical privileges.

(g) No history of subjection to involuntary terminations of medical staff membership in another organization.

(h) The reason temporary privileges are being requested.

(i) Query and evaluation of a National Practitioner Data Bank Report.

(j) No findings on a criminal background check.

(k) No history of exclusion from any federal or state government healthcare program.

7.6.5. Limitations. Any practitioner granted temporary privileges to provide for locum tenens services for a Member shall be limited to admitting and treating patients of the Member including any on call responsibilities.

7.6.6. Termination. Temporary privileges may be suspended, modified, or revoked at any time by the Administrator and Medical Staff President with the concurrence of the Medical Executive Committee without giving rise to the right of a hearing and appeal under these Bylaws. Upon suspension or termination of temporary privileges, the Medical Staff President shall assign a member of the Medical Staff to assess the condition of any patient(s) then in the Hospital under the care of the practitioner whose privileges have been suspended or terminated. The Medical Staff President shall ensure medical care is provided to such patient and/or to discharge the patient(s) from the Hospital.

7.6.7. No Procedural Rights. The denial of any request for temporary privileges or termination or suspension of temporary privileges, whether in whole or in part, do not give rise to any procedural rights under the Bylaws.

Section 7.7. Emergency Privileges. In case of an emergency as defined below, any Privileged Practitioner attending a patient shall be expected and permitted to do everything in their power and to the degree permitted by their license, to save the life of the patient or prevent significant and disabling morbidity regardless of the delineation of clinical privileges. This duty shall be subject to the Privileged Practitioner's concurrent duty to consider or abide by a patient's directives under Indiana law to withhold or withdraw life-sustaining procedures or to consider 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 no longer exists, the patient shall be assigned to an appropriate Member who holds clinical privileges appropriate to address the patient's medical conditions.

Section 7.8. Reciprocal Disaster and Disaster Privileges.

7.8.1. Reciprocal Disaster Privileges. Whenever an emergency management plan is activated and the Hospital is unable to handle immediate patient care needs, the authority to implement disaster privileges is at the direction of the Hospital

Command Center, in consultation with the Medical Staff leadership. In such a circumstance and for the duration of the emergency, all clinical privileges currently granted to Members and Allied Health Practitioners at any Network hospital or any facility where Network is the majority owner ("Network facility") may be exercised at any Network hospital, Network facility, or any other location being used by the hospitals for patient care (hereinafter referred to as "Reciprocal Disaster Privileges") so long as the Hospital has clinical privileges forms and policies that include the category of health care professional.

7.8.2. Disaster Privileges. Disaster Privileges may be granted to a Physician who volunteers but does not hold clinical privileges at any Network hospital or facility by the Administrator or designee or any elected Medical Staff Officer once appropriate identification is obtained from the Physician. Primary source verification of licensure and current photo identification card 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. The reason for the Hospital's inability to verify will be documented with evidence of the volunteer Physician's demonstrated ability to continue to provide adequate care, treatment, and services.

7.8.3. Scope of Privileges. Any Practitioner exercising Reciprocal Disaster Privileges or volunteering Physician exercising Disaster Privileges shall be paired with and supervised by an on-site Member with clinical privileges and wear an approved form of identification. The scope of the Disaster Privileges shall be consistent with established core clinical privileges and as determined by the on-site supervising Member.

7.8.4. Evaluation of Privileges. Within 72 hours of exercising Reciprocal or Disaster Privileges, an evaluation of competency will be completed by the on-site Member and submitted to Medical Staff leadership for review. Upon review of the evaluation, Medical Staff leadership will assess the professional practice of the volunteer Physician or Practitioner and the need for continuation or modification of Disaster Privileges or Reciprocal Privileges granted. Whenever any information received through the verification process or the professional practice evaluation review indicates adverse information suggesting the practitioner is not capable of rendering services in an emergency, the privileges may be immediately terminated by Medical Staff leadership.

7.8.5. Termination of Privileges. Reciprocal and Disaster Privileges will be in effect for the duration the declared emergency. Such privileges will automatically expire when the declared emergency is no longer in effect.

Section 7.9. Telehealth and Distant Site Provider Privileges.

7.9.1. Clinical Privileges Exercised through Telehealth Link. The Governing Body upon the advice of the Medical Staff determines which services are appropriate to be delivered via a telehealth link. Members currently credentialed and privileged, who provide the same services via a telehealth link to patients, do not require any additional credentialing or privileging. There is no requirement that telehealth be delineated as a separate clinical privilege.

7.9.2. Distant Site Telemedicine Privileges Limited Eligibility. Distant Site Telemedicine Privileges are only available to Applicants who have existing clinical privileges at a Joint Commission accredited distant site hospital or organization that has a written contract with the Hospital to provide distant site telemedicine services to Hospital patients (hereinafter referred to as "Distant Site Hospital").

7.9.3. Application Process. When distant site telemedicine services are to be furnished to the Hospital through such contract, in lieu of the process in Section 6.2.5, the Medical Director and Medical Executive Committee may rely upon the credentialing and privileging decision of the Distant Site Hospital to make recommendations on an individual distant site Applicant so long as:

(a) the individual Applicant is privileged at the Distant Site Hospital to provide the telemedicine services;

(b) the Distant Site Hospital provides a current list of the distant site individual providers which includes the Applicant; and

(c) the Distant Site Hospital provides evidence of an internal review of its distant site individual Privileged Practitioners.

7.9.4. Additional Effect of Acknowledgement. Such Applicant acknowledges that the Hospital will send information, including otherwise privileged or confidential information, to the Distant Site Hospital that is useful to assess the distant site telemedicine Privileged Practitioner's quality of care, treatment, and services for performance improvement, and recredentialing as set forth in the Medical Staff Telemedicine Policy.

7.9.5. Limited Membership. Individuals granted distant site telemedicine privileges shall not be eligible to be voting members of the medical staff.

7.9.6. Temporary Privileges. Applicants requesting distant site telemedicine privileges may be eligible for temporary privileges through the process outlined in Section 7.6.

Section 7.10. Voluntary Leave of Absence.

7.10.1. Written Request. A Member may request a voluntary leave of absence from the Medical Staff using the Medical Staff Leave of Absence Form. Except for leaves precipitated by an acute, unavoidable need such as a medical condition or military duty, the written request should be submitted as soon as possible and prior to the requested leave date, and state (1) the reason for the leave, (2) the

requested period of leave time, which may not exceed one (1) year, (3) the plan for alternate coverage for proper and necessary patient care during the requested absence, and (4) pledge to complete all medical records before the leave takes effect, if granted. Absence based on military duty shall be deemed an automatic leave of absence. To prevent gaps in appointments, the Member may need to submit a reappointment Application with the request.

7.10.2. Leave Review Process. A request for leave of absence, except those precipitated by an acute medical condition or military duty, will not be considered until all obligations to the Hospital have been met or the request sets forth a plan of action to address such obligations, including completion of all medical records, payment of any outstanding dues and fines, and fulfillment of any emergency department or other call obligations. The request will be submitted to the Medical Director who will submit it to the Medical Executive Committee for its consideration at its next regular meeting. The Medical Executive Committee will review such requests and approve or disapprove the request. The Medical Executive Committee will routinely report all leaves to the Governing Body.

7.10.3. Approved Requests. Whenever a request is approved, the Member shall complete all patient medical records before the leave of absence takes effect, pay in advance any dues anticipated to accrue during the absence, and make necessary arrangements to provide alternate coverage and advise the Medical Director in writing of such arrangements.

7.10.4. Effect of Leave. During the period of a leave, the Member's membership and clinical privileges are inactivated and the Member is relieved from all prerogatives, responsibilities, and duties of membership and clinical privileges.

7.10.5. Denied Requests. Whenever the Medical Executive Committee does not approve such request, the requesting Member shall not be entitled to procedural rights as outlined in the Hearing and Appeal Sections of these Bylaws.

7.10.6. Request to Return. Prior to the expiration of the leave, the Member must request reinstatement in writing which may be through electronic communication. As part of the request, the Member must submit a written summary of any clinically relevant activities during the leave if requested by Members the Medical Executive Committee. Whenever a leave was requested due to potential impairment because of a medical condition, aging, or alcohol or drug abuse, the Member will be required to demonstrate that the Member meets the Threshold Eligibility Criteria related health status.

7.10.7. Return Request Review Process. All requests for reinstatement must be reviewed by the and acted on by the Medical Executive Committee. If the requested return date is after the Member's current appointment expires, the returning Member will be required to submit a reapplication form and be reappointed by the Governing Body.

7.10.8. Adverse Recommendation on Return Request. If the recommendation of the Medical Executive Committee is a proposed Adverse Action giving rise to a hearing under these Bylaws, then the Member shall be entitled to the procedural process under the Hearing and Appeals Article of these Bylaws.

7.10.9. Failure to Request Return. If the Member fails to request reinstatement before the expiration of the leave, and/or the appointment term expires during the leave, the membership and clinical privileges will be deemed relinquished. Such a relinquishment may be reportable if the Member was the subject of an investigation or non-routine FPPE at the time the leave was granted. The affected Member shall not be entitled to any procedural rights as outlined in the Hearing and Appeal Articles of these Bylaws. A Member in good standing who fails to timely seek reinstatement may be reinstated upon the completion and approval of a reappointment Application within 12 months of the start of the leave of absence.

Section 7.11. Allied Health Practitioner Staff. Certain licensed health care professionals are eligible to seek clinical privileges as Allied Health Practitioners. The Medical Staff is required to assess the qualifications of such Applicants and provide oversight to their clinical work. The scope and extent of clinical privileges granted to an Allied Health Practitioner shall be limited by the scope of the clinical privileges of the sponsoring Member. The evaluation process for Applicants seeking appointment to the Allied Health Practitioner Staff, which is stated more fully in the Medical Staff Allied Health Practitioner Policy, includes a determination of the Application's completeness, satisfaction of the applicable Threshold Eligibility Criteria, and recommendations by the Medical Director and the Medical Executive Committee with the final determination made by the Governing Body. Allied Health Practitioners are not members of the Medical Staff.

Section 7.12. Advanced Trainees. Advanced Trainees are either non-employed residents and fellows (visiting residents and fellows) or employed residents and fellows under the Network's Office and Administration of Graduate Medical Education (GME Office). Advanced Trainees will not be required to request specific clinical privileges, unless required by an Accreditation Body. Advanced Trainees must carry out any clinical care in accordance with the written educational protocols developed by the GME Office and approved by Graduate Medical Education Committee of the Network (GMEC) and their respective training programs. All employed residents and fellows will operate under the GME handbook, GMEC policies and procedures, and Network and program processes. Visiting residents and fellows must enter the Network through approval by the GME Office with specific documentation for curriculum, training, and supervision by an approved program of either the Accreditation Council on Graduate Medical Education, the American Osteopathic Association, the Council on Podiatric Medicine Education, or the Network. The Network GME Office issues the requirements for oversight of Advanced Trainees, the types of orders they may write, when such orders must be countersigned, and by whom through protocols. These protocols must delineate the roles, responsibilities, and scope of clinical activities applicable to Advanced Trainees. Advanced Trainees are not members of the Medical Staff.

ARTICLE 8 - AUTOMATIC SUSPENSION OR RESTRICTION

Section 8.1. General Provisions. Automatic suspensions do not give rise to any hearing or appeal rights. Automatic suspensions are not considered professional review actions because they are not based on a determination of professional competence or professional conduct of the Privileged Practitioner by a Peer Review committee. They are imposed by notice to the Member by the appropriate Medical Staff committee, Medical Executive Committee, or Administrator. Automatic suspensions are terminated by the Member's compliance with the involved requirement except as provided specifically otherwise.

Section 8.2. Grounds. An automatic suspension shall be imposed effective upon verified information of any of the following.

(a) The Member has made a false representation during the appointment and privileging process.

(b) The Member's license to practice their profession is suspended or terminated.

(c) The Member's registration to dispense, prescribe or administer any controlled substance is surrendered, restricted, suspended, or terminated. The automatic suspension shall be limited to the Member's privileges to order, administer or prescribe such controlled substance.

(d) The Member fails to maintain professional liability insurance as a Qualified Provider.

(e) The Member no longer meets the Threshold Eligibility Criteria for membership or clinical privileges.

(f) The Member fails to personally appear at a meeting for which the Member was given notice of a suspected deviation from standard clinical practice or unacceptable professional behavior.

(g) The Member's clinical privileges have been suspended at another Healthcare Entity.

(h) The Member fails to complete their medical records within the time frames set forth in the Policies except that the suspension is limited to the Member's ability to exercise clinical privileges on any new patient Encounter including admitting privileges.

Section 8.3. Effect on AHP. An automatic suspension shall be imposed effective immediately on any Allied Health Practitioner whose legal prescribing authority derives from either a supervising agreement or collaborative agreement with the Member who is suspended unless such agreement identifies another Member as a designee.

Section 8.4. Limited Review of Certain Automatic Suspensions. Any automatic suspension based on license, controlled substance registration, or another Healthcare Entity suspension shall not be lifted until the Medical Executive Committee votes on whether to initiate its own investigation.

Section 8.5. Remedy to Lift Automatic Suspension. If a Member temporarily fails, for administrative reasons, to meet the criteria for licensure, state and federal controlled substance registration, professional liability insurance, mandatory education within established time frames, the Member may present, within a reasonable time not to exceed sixty (60) days, evidence to the Medical Staff Office that such non-compliance has been corrected for review by the Medical Director. Upon verification that such evidence verifies that the lapse was administrative and corrects the non-compliance, the clinical privileges of the Member may be reinstated. The Medical Director may defer to the Medical Executive Committee in any circumstance where the chair determines that the evidence should be further evaluated prior to reinstatement. If no such evidence is presented within sixty (60) days, the Member will be deemed to have voluntarily resigned. Suspended Members who no longer meet any other Threshold Eligibility Criteria will be deemed to have voluntarily resigned.

ARTICLE 9 - PEER REVIEW MONITORING OF CARE AND CONDUCT

Section 9.1. Opportunities to Improve. The Medical Staff strives to continuously improve the professional performance of the Medical Staff and the Allied Health Practitioner Staff through routine peer review activities. Any person may provide information about the conduct, performance, or competence of any Member or Privileged Practitioner. When reliable information indicates a Member or Privileged Practitioner may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (2) unethical or illegal; (3) contrary to the Medical Staff Bylaws or Policies or any applicable Hospital or Network Policy; (4) harassing or intimidating; (5) disruptive of Hospital or Medical Staff operations; (6) below applicable professional standards or standards established by the Medical Staff; or (7) harmful to the reputation of the Medical Staff or Hospital and its culture of safety, the reported concern should be directed to the appropriate medical staff peer review committee overseeing the ongoing professional performance improvement activities of the Member or Privileged Practitioner as set forth in these Bylaws and Policies. The Member or Privileged Practitioner may be notified of the nature of the complaint and may be asked for a written response. Depending on the nature of the reported concern and other circumstances, the reported concern may be addressed through a collegial intervention or a more formal process. When the concerns involve the professional competence or professional conduct of a Privileged Practitioner on the Allied Health Practitioner Staff, the Medical Staff will follow the Medical Staff Allied Health Practitioner Policy.

Section 9.2. Collegial Intervention. The Medical Staff leadership may, but is not required to, address any reported concern collegially so long as patient safety is not jeopardized, and the Member or Privileged Practitioner demonstrates an improvement in professional performance or professional conduct. A collegial discussion or intervention to address concerns about performance or conduct is an informal routine peer review activity. It may be conducted by a Medical Staff officer, the Physician Network Executive, or Administration in their capacity as a member of a medical staff committee with peer review responsibilities. Collegial interventions undertaken by any Medical Staff officer, Administration, Network Physician Executive, the Medical Executive Committee and any recurring collegial efforts made by the Medical Director should be documented. The documentation should be provided to the Medical Executive Committee. The documentation of such activities will be maintained consistent with other peer review information. When collegial interventions fail or are insufficient to protect the well-being

of others, or the orderly operations of the Hospital and its programs, the Medical Executive Committee will evaluate the situation and recommend further action.

Section 9.3. Investigation.

9.3.1. Criteria for Initiation. Whenever circumstances require an in-depth review of allegations, the Medical Executive Committee or, if time is of the essence, the Medical Staff President acting on behalf of the Medical Executive Committee may initiate an investigation. Such investigation may be referred to the appropriate Medical Staff committee to carry out. Unless necessary to protect patient safety or prevent disruption to the operation of the Hospital, the Member whose conduct is the subject of the investigation will be notified and may be provided an opportunity to respond to the allegations even if the member has previously responded.

9.3.2. Investigation Committee. The investigation committee may be the Medical Executive Committee, or its subcommittee, or any other standing Medical Staff committee, or an ad hoc committee. The committee will investigate the allegations at issue. The investigation committee, at its discretion, may interview the Member whose conduct is the subject of the investigation. The investigation committee shall make a written report of the information gathered, and any additional concerns uncovered, and recommend further handling to the Medical Executive Committee. If the Medical Executive Committee conducts the investigation, in lieu of a report to itself, the investigation results may be detailed in the minutes of the Medical Executive Committee. The initiation of or an ongoing investigation shall not prevent any authorized committee from imposing a precautionary suspension as warranted.

9.3.3. Medical Executive Committee Recommendation. At its next meeting, the Medical Executive Committee will review the investigation report, and recommend the action to be taken. The Medical Executive Committee may:

(a) decide no further action is warranted.

(b) issue a warning, a letter of admonition, education or of reprimand. In the event letters are issued by the Medical Executive Committee, the affected Member may make a written response that shall be placed in the Member's file.

(c) impose terms of probation or a requirement for co-admission or mandatory consultation, or monitoring.

(d) recommend reduction, modification, suspension, or revocation of clinical privileges.

(e) recommend reduction of appointment status or limitation of any prerogatives directly related to the Member's delivery of patient care.

(f) recommend that an already imposed summary suspension of clinical privileges be terminated, modified, or sustained.

(g) recommend that the Member's Membership be suspended or revoked.

(h) take other actions deemed appropriate under the circumstances.

9.3.4. Governing Body Action. The recommendation of the Medical Executive Committee shall be forwarded to the Governing Body. With Governing Body approval, the recommendation shall become final action unless the Member is entitled to the hearing and appeal procedures, in which case the final decision shall be determined as set forth in Article 10. Nothing in this Article precludes the Governing Body from investigating concerns brought to the Governing Body's attention or appointing a committee to investigate on its own behalf.

9.3.5. Monitoring. Periods of monitoring, continuing education requirements, and other remedies that require additional evaluation to determine compliance and improvement shall be items of continuing recurrence on the Medical Executive Committee agenda until resolution of the underlying issue. The Wellness Committee will be responsible for monitoring those Privileged Practitioners referred to it.

Section 9.4. Precautionary Suspension or Restriction.

9.4.1. Grounds. Unless initiated and approved by the Governing Body, whenever there is a reasonable possibility that failure to take action may pose a danger to the health or safety of any individual or may disrupt the orderly operation of the Hospital, the Medical Executive Committee, or acting as a Peer Review Committee no less than two (2) of the following individuals or designees: the Medical Staff President, the Administrator, or the Physician Network Executive are authorized (1) to afford the Privileged Practitioner an opportunity to voluntarily refrain from exercising clinical privileges pending an investigation; or (2) as a precaution, immediately to suspend or restrict all or any portion of the clinical privileges of the Privileged Practitioner. When possible, prior to the imposition of a precautionary suspension or restriction, the Peer Review Committee may meet with the affected Privileged Practitioner so the Privileged Practitioner may hear the concerns and offer a rebuttal.

9.4.2. Definition. A precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It will not imply any final finding of responsibility for the situation that caused the suspension or restriction. A precautionary suspension or restriction can be imposed at any time following a specific event; a pattern of events; failing to respond to quality or behavioral concerns; failing to respond or personally appear as requested at a meeting before a committee or oversight body; or following a recommendation by the Medical Executive Committee that would entitle the Privileged Practitioner to request a hearing.

9.4.3. Procedural Rights. Unless otherwise indicated, the precautionary suspension will take place immediately. The Peer Review Committee responsible for imposing the precautionary suspension will promptly notify the affected Privileged Practitioner, the Medical Executive Committee, the Administrator, Network Physician Executive, and the Governing Body Chair. If the affected Privileged Practitioner is employed by the Network, the Community Physician Network's Professional Practice Evaluation Committee (CPN PPEC) will be notified. If not provided at the time of suspension, within three (3) days of the imposition of a suspension or restriction, the affected Privileged Practitioner shall be provided a brief written description of the reason(s) for the action, including the identified names and medical record numbers of the patient(s) involved, if any. A precautionary suspension shall remain in effect until resolved as set forth herein. If the Privileged Practitioner is an Allied Health Practitioner, the subsequent procedures are set forth in the Medical Staff Allied Health Practitioner Policy.

9.4.4. Medical Executive Committee Review. The Medical Executive Committee will review the reasons for the precautionary suspension or restriction within a reasonable time, not to exceed (14) fourteen days. As part of this review, the Member will be given an opportunity to meet with the Medical Executive Committee. This meeting is not intended to be a hearing and the Member will not have the right to call and examine or cross-examine witnesses. The Member may be accompanied by counsel, who may advise the Member, but counsel will not be permitted to address the Medical Executive Committee. The Privileged Practitioner may propose ways other than precautionary suspension or restriction to protect patients, employees, or the orderly operation of the Hospital. After considering the reasons for the precautionary suspension or restriction and the Member's response, if any, the Medical Executive Committee will determine whether the precautionary suspension or restriction should be continued, modified, or terminated. The Medical Executive Committee will also consider if another Peer Review Committee should be assigned to further investigate. Whenever a precautionary suspension extends beyond fourteen (14) days, the Member may request a hearing as described in Article 10. There is no right to a hearing or appeal based on the imposition or continuation of a precautionary suspension or restriction that is in effect for 14 days or less.

9.4.5. Patient Reassignment. Unless otherwise indicated by the terms of the precautionary restriction or suspension, the Member's patient(s) shall be promptly assigned to another Member by the Medical Staff President considering, where feasible, the wishes of the patient in the choice of a substitute Member.

ARTICLE 10 - HEARING AND APPEAL

Section 10.1. Purpose. The purpose of these hearing and appeal provisions is to provide a process for resolving, on an intra-professional basis, matters bearing on professional competency and conduct. Because such proceedings utilize resources that could be used for providing and/or improving patient care, the Medical Staff and Hospital have decided to make available the hearing and appeal procedures set forth in these Bylaws to only eligible Members of the Medical Staff and

Applicants. To be eligible, the Member or Applicant must be the subject of a significant proposed Adverse Action based on professional qualifications, competency, or conduct, that if approved by the Governing Body, must be reported to the National Practitioner Data Bank and the applicable state professional licensing authority. A Member or Applicant who is not eligible for the hearing and appeal procedures may request an opportunity for an audience before the Medical Executive Committee to discuss the action or recommendation and/or submit a written rebuttal to be maintained with the notice of the action or recommendation.

Section 10.2. Exhaustion of Remedies. If any proposed Adverse Action as defined in these Bylaws is taken or recommended, the Applicant or Member must exhaust the remedies afforded by these Bylaws before resorting to any legal action or judicial review.

Section 10.3. Right to Hearing and Appeal.

10.3.1. Actions Giving Rise to Hearing. When a Member or Applicant receives notice of a proposed Adverse Action or when a precautionary suspension exceeds fourteen (14) days (hereinafter "Affected Practitioner"), the Affected Practitioner shall be entitled to one (1) evidentiary hearing as provided herein. If the recommendation of the Medical Executive Committee following such hearing remains a proposed Adverse Action to the Affected Practitioner, then the Affected Practitioner shall be entitled to one (1) appellate review prior to the Governing Body making a final decision on the matter. When the Affected Practitioner receives notice of a Governing Body's decision based on professional competence or professional conduct that will Adversely Affect the membership or clinical privileges of the Affected Practitioner, and such decision is not based on a pending proposed Adverse Action of the Medical Executive Committee, the Affected Practitioner shall be entitled to a hearing as provided in these provisions. If such hearing does not result in a favorable recommendation, the Affected Practitioner shall be entitled to an appellate review by the Governing Body or a committee thereof before the Governing Body makes a final decision on the matter.

10.3.2. Actions Not Giving Rise to Hearing Right. The following recommendations or actions do not give rise to a hearing or appeal:

(a) Issuance of a letter of guidance, warning, or reprimand.

(b) Automatic suspension or limitation.

(c) Precautionary suspension for a period of less than fourteen (14) days.

(d) Denial of a leave of absence request, an extension of a leave of absence, or reinstatement after such leave.

(e) Determination that any Application is untimely or incomplete.

(f) Decision not to process an Application under the available procedures for expedited review.

(g) Assignment to a Medical Staff membership category.

(h) Imposition of a proctoring or monitoring requirement where such does not include a restriction on clinical privileges.

(i) Failure to process an Application for membership or clinical privileges because the Applicant does not meet the Threshold Eligibility Criteria for membership or additional requirements for clinical privileges as set forth in the applicable clinical privilege form.

(j) Imposition of focused professional practice evaluation, external case review, or investigation.

(k) Request to personally appear for a special meeting.

(l) The termination or limitation of temporary privileges.

(m) Ineligibility to request membership or clinical privileges or continue the exercise of such privileges because the Hospital enters into an exclusive agreement for the provision of certain services.

(n) Termination of any contract with or employment by the Hospital.

(o) Recommendation voluntarily accepted by the Member because of collegial intervention.

(p) Removal or limitation of emergency service call obligations.

(q) Any requirement to complete an educational assessment.

(r) Any requirement to undergo a health assessment or fitness for duty evaluation.

(s) Appointment for a duration of less than 24 (twenty-four) months.

(t) Refusal by the Hospital to provide an Application form.

(u) Refusal to grant a request for a waiver or extension of time regarding any Threshold Eligibility Criteria.

(v) Any other recommendation or action that does not Adversely Affect the clinical privileges of any Member.

Section 10.4. Expedited Hearing. A hearing for an Affected Practitioner who is under suspension shall be held as soon as arrangements therefore may reasonably be made, if the Affected Practitioner requests in writing such an expedited hearing date and waives the usual deadlines as stated below in favor of an expedited process.

Section 10.5. Notice of Proposed Adverse Action. Whenever any proposed Adverse Action is made, the Administrator shall be responsible for sending the written notice to the Affected Practitioner within ten (10) days by secure electronic mail. Such notice shall contain the following:

(a) the proposed Adverse Action.

(b) the reasons for the proposed Adverse Action including representative records and/or incident or committee reports if known at the time.

(c) the statement that a hearing, if desired, must be requested within thirty (30) days; and

(d) a summary of Affected Practitioner's hearing rights.

Section 10.6. Request for Hearing. The Affected Practitioner shall have thirty (30) days from receipt of the notice in which to request a hearing via secure electronic mail to the Administrator. The failure to request a hearing within the time and in the manner herein provided shall be deemed a waiver of the Affected Practitioner's right to such hearing and any appellate review. A waiver of a hearing right as to a proposed Adverse Action also waives a hearing right as to the Adverse Action. When the waived hearing or appellate review relates to a proposed Adverse Action of the Medical Executive Committee, the recommendation shall thereupon become and remain effective against the Affected Practitioner pending the Governing Body's decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Governing Body, the same shall thereupon become and remain effective against the Affected Practitioner until a final decision of the Governing Body is made. In either of such events, the Administrator shall promptly notify the Affected Practitioner of their status by secure electronic mail.

Section 10.7. Hearing Arrangements, Date and Notification.

10.7.1. Hearing Arrangements. Within fifteen (15) days after receipt of a request for hearing, the Administrator shall select a hearing date.

10.7.2. Hearing Date. The hearing date shall not be fewer than thirty (30) days nor more than sixty (60) days from the date of receipt of the Affected Practitioner's request for hearing unless otherwise agreed.

10.7.3. Notification of Hearing Date. The Administrator shall notify the Affected Practitioner of the time, place, and date so scheduled, by secure electronic mail. The written notification of the hearing date shall also:

(a) list witnesses, if any, expected to testify and a summary of their expected testimony;

(b) identify specific or representative charts being questioned;

(c) inform the Affected Practitioner of the right to representation by an attorney licensed to practice law in Indiana or a Member in good standing and that the Affected Practitioner must advise the Administrator within seven (7) days after the hearing notice of the name and address of any such representative; and

(d) inform the Affected Practitioner of the requirement to provide to the Administrator at least fourteen (14) days after the hearing notice:

i. a statement setting forth the reasons why the Affected Practitioner contends the proposed Adverse Action lacks any factual basis or should be overturned;

ii. a list of witnesses the Affected Practitioner will call to testify and a summary of the subject matter of each witness's testimony; and

iii. a copy of all documents the Affected Practitioner intends to introduce at the hearing.

Section 10.8. Hearing Committee.

10.8.1. Qualifications. When a hearing relates to a proposed Adverse Action of the Medical Executive Committee, the Hearing Committee shall be appointed by the Administrator and shall consist of at least three (3) Members of the Medical Staff. The Hearing Committee shall have no Members (i) who actively participated in initiating or investigating the underlying matter at issue or was responsible for making the proposal giving rise to the hearing unless it is otherwise impossible to select a representative because of the size of the Medical Staff, or (ii) who are in "direct economic competition" with the Affected Practitioner for whom the hearing has been scheduled. "Direct economic competition" (for the purposes of this section of the Bylaws) means the "Member practices in the same specialty as the Affected Practitioner." Employment by or a contract with the Hospital, Community Health Network, or any affiliated hospital will not preclude a Member from serving on the Hearing Committee. When a hearing relates to an adverse decision of the Governing Body that is contrary to the non-Adverse Action recommendation of the Medical Executive Committee, the Hearing Committee shall be appointed by the Governing Body and shall consist of one member of the Governing Body as the chairperson and at least two (2) representatives from the Medical Staff. These representatives will meet the standards set forth in this Section.

10.8.2. Notification. The parties shall be notified of the Members appointed to serve as the Hearing Committee.

10.8.3. Objections. Within seven (7) days of such notification, the parties may object to any of the appointed Members. The Administrator shall consider the merits of such objection and in the Administrator's sole discretion replace that Member. Failure to object in a timely manner to a Hearing Committee Member constitutes a waiver of such objection.

Section 10.9. Hearing Officer. The Administrator shall select a Hearing Officer. The Hearing Officer shall act as presiding officer to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and written evidence.

(a) The Hearing Officer may be either a Member of the Hearing Committee, a retired judge or an attorney experienced in healthcare law who is not regularly employed

or engaged by any parties to the hearing for duties other than acting as Hearing Officer.

(b) If the Hearing Officer is not a Member of the Hearing Committee, then the parties may advise the Administrator in writing within seven (7) days from the notice of the Hearing Officer identity of any objection to the selected Hearing Officer. The Administrator shall determine the merits of such objection and may select another Hearing Officer.

(c) The Hearing Officer shall coordinate a date and time for the exchange of lists of witnesses (if any) expected to testify and copies of exhibits. Any witness not then identified, and any exhibit not provided may in the discretion of the Hearing Officer be excluded.

(d) The Hearing Officer shall be entitled to determine the order of proceeding during the hearing, to promulgate rules and procedures not inconsistent with the Bylaws, to exclude or remove any person who is disruptive to an orderly and professional hearing, and perform other responsibilities assigned to the Hearing Officer.

(e) The Hearing Officer shall set reasonable time limits on the hearing.

(f) The Hearing Officer may participate in the deliberations, act as an advisor, and write the report and recommendation for the Committee, but he may not vote unless he is a Member. In other words, service by a Member of the Hearing Committee, as Hearing Officer, shall not in any way prevent such Member from full participation in the deliberations and actions of the Hearing Committee.

Section 10.10. No Discovery. Except as specifically provided in this provision, there shall be no right to conduct discovery in connection with any hearing or appeal and no Affected Practitioner shall be permitted access to any Peer Review Committee records, medical records, minutes, or other documents relating to any other Privileged Practitioner, or any action taken or not taken regarding any other Privileged Practitioner. In advance of the hearing, the Affected Practitioner will be provided a copy of any materials gathered by the Medical Executive Committee in making its proposed Adverse Action, any documents to be used at the hearing, and any medical records relied on or to be used at the hearing. The production of such documents shall not constitute a waiver of any peer review protection for those documents or any other documents, and the use of peer review documents for any other purposes other than described herein is not permitted. The Affected Practitioner may be asked to sign an acknowledgement related to keeping such documents confidential and the duty to invoke the peer review privilege. Failure to request this acknowledgement is not a waiver of the peer review privilege.

Section 10.11. Hearing.

10.11.1. Personal Appearance Requirement. The personal presence of the Affected Practitioner for whom the hearing has been scheduled shall be mandatory. An Affected Practitioner who fails, without good cause, to appear and proceed at such hearing shall be deemed to have forfeited their rights and to have accepted the proposed Adverse Action, and the same shall thereupon become and remain in effect until Governing Body action.

10.11.2. Continuance. Postponement of the hearing beyond the time set forth in this Policy shall be made only with the approval of the Hearing Committee or Hearing Officer. Granting of such postponements shall only be for good cause shown and in the sole discretion of the Hearing Committee or Hearing Officer.

10.11.3. Representation. The Affected Practitioner shall be entitled to be accompanied by and represented at the hearing by a Member of the Medical Staff in good standing or by an attorney licensed to practice in Indiana at their own expense. When the Medical Executive Committee's action has prompted the hearing, a Member of the Medical Executive Committee shall be appointed to represent the Committee's position at the hearing and to present the facts, documents, and any witnesses in support of its proposed Adverse Action. The Governing Body, when its action has prompted the hearing, shall appoint a director to represent it at the hearing, to present the facts, documents, and witnesses in support of its adverse decision. The Medical Executive Committee or Governing Body may be also represented by an attorney retained at the Hospital's expense. If the Affected Practitioner chooses to be represented by legal counsel, then the Medical Staff or Governing Body must also be represented by legal counsel in the proceedings.

10.11.4. Committee. A majority of the Members of the Hearing Committee shall be present when the hearing takes place. No Member may vote by proxy.

10.11.5. Record. An accurate record of the hearing must be kept. The mechanism shall be established by the Hearing Officer. An accurate record may be accomplished by use of a court reporter, electronic recording unit, or detailed transcription.

10.11.6. Evidence. The hearing shall not be conducted according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in any civil or criminal action.

10.11.7. Written Statements. The parties shall, prior, during, or within a time frame after the hearing established by the Hearing Officer or committee chairman, be entitled to submit memoranda concerning any issue of procedure or of fact, and such memoranda shall become a part of the hearing record.

10.11.8. Affected Physician Testimony. If the Affected Practitioner does not testify on their own behalf, they may be called and examined as if under cross-examination.

Section 10.12. Standard Burden of Proof.

(a) Whenever a hearing related solely to the proposed denial of or limitation of appointment, reappointment, or requested clinical privileges, the Affected

Practitioner shall bear the burden of proving, by clear and convincing evidence, (i) that the Affected Practitioner meets the standards for appointment or reappointment to the Medical Staff or for the granting of clinical privileges requested and (ii) that the denial of or limitation of the appointment, reappointment, or requested clinical privileges is arbitrary and capricious.

(b) In all other cases, either the Medical Staff Executive Committee or the Governing Body depending on whichever Peer Review committee proposed the Adverse Action, shall present supporting evidence, but the Affected Practitioner shall have the burden of proving, by clear and convincing evidence, that the proposed Adverse Action should be rejected and/or modified, in whole or in part.

Section 10.13. Hearing Rights. At the hearing, the Affected Practitioner and Medical Executive Committee have the right:

(a) to call, examine, cross-examine witnesses.

(b) to present evidence determined to be relevant by the hearing officer.

(c) to submit a written statement at the close of the hearing.

(d) to have a record made of the proceedings, copies of which may be obtained by either party upon payment of any reasonable charges associated with the preparation thereof; and

(e) upon completion of the hearing, to receive a copy of the written findings and recommendation of the Hearing Committee.

Section 10.14. Recess/Adjournment. The Hearing Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence. Upon conclusion of all evidence, the hearing shall be closed. The Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Affected Practitioner for whom the hearing was convened. The Hearing Committee may recess the hearing at its conclusion until a transcript can be provided. After receipt of all the written and oral evidence; written statements of the parties, if submitted to the Hearing Committee; the transcript of the hearing, if submitted to the Hearing Committee; and after the completion of the deliberations of the Hearing Committee, the hearing shall be adjourned.

Section 10.15. Hearing Committee Report and Recommendation.

10.15.1. Within thirty (30) days after final adjournment of the hearing, the Hearing Committee shall make a written report and recommendation. This report and recommendation shall be forwarded with the record of proceedings to whichever committee's action triggered the hearing, the Medical Executive Committee or Governing Body.

10.15.2. A copy of the Hearing Committee's report and recommendation shall also be sent by secure electronic mail to the Affected Practitioner, Medical Staff President, and the Administrator.

10.15.3. The report may recommend confirmation, modification, or rejection of the original proposed Adverse Action. The body receiving the report shall, at a special meeting called to consider the matter or at its next regularly scheduled meeting after its receipt, but in any event no longer than forty-five (45) days after receiving it, review it.

10.15.4. A majority vote of the body present is required to modify or reject the original proposed Adverse Action. Written notice of the action taken shall be sent by secure electronic mail, to the Affected Practitioner. The recommendation will not be forwarded to the Governing Body for final action until the Affected Practitioner has exercised or been deemed to have waived their right to an appeal.

Section 10.16. Appeal to the Governing Body.

10.16.1. Requesting an Appeal. Within seven (7) business days after receipt of a notice by an Affected Practitioner of a proposed Adverse Action or decision made or adhered to by the Medical Executive Committee or Governing Body after a hearing as provided above, the Affected Practitioner may request an appeal to the Governing Body in writing via secure electronic mail. A copy of the request shall be sent to the Medical Staff President. The Affected Practitioner may also request an oral argument be permitted as part of the appellate review. Oral arguments may be permitted in the sole discretion of the Governing Body as part of appellate review. If appellate review is not requested within seven (7) business days, the Affected Practitioner shall be deemed to have waived the right to the same, and to have accepted such proposed Adverse Action or decision, and the same shall become effective immediately when acted upon by the Governing Body.

10.16.2. Standard of Appellate Review. Appellate review shall be limited to determining whether the Affected Practitioner has established by clear and convincing evidence that (1) there had been a substantial failure to comply with the Medical Staff Bylaws during the corrective action which has materially prejudiced the Affected Practitioner; (2) the recommendation is arbitrary and unreasonable; or (3) the recommendation is not supported by reliable evidence.

10.16.3. Written Statement of Affected Practitioner. The Affected Practitioner must submit a written statement to the Governing Body setting forth specifically any finding of fact, conclusions, recommendations, and procedural matters with which the Affected Practitioner disagrees and the reasons therefor. Failure to identify any finding of fact, conclusions, or procedural matters with which the Affected Practitioner disagrees shall constitute a waiver of those issues. Only those findings of fact, conclusions, or procedural matters listed will be considered on appeal. The Affected Practitioner's written statement shall be submitted to the Governing Body through the Administrator by certified mail, return receipt requested, ten days (10) days after the mailing of the request for the appeal. The Affected Practitioner shall provide a copy of the written statement to the Medical Executive Committee, which may submit a response to the Governing Body, with a copy to the Affected Practitioner within ten (10) days after receipt. Failure to

submit the written statement within the above-listed time limits waives the Affected Practitioner's right to file such a statement.

10.16.4. Notice of Appellate Review Date. Promptly after receipt of request for appellate review, the Chair of Governing Body shall schedule a date for such review, including a time and place for oral argument, if such has been requested and granted and shall, through the Administrator, by written notice sent by secure electronic mail, notify the Affected Practitioner and Medical Staff representative of the same. The date of the appellate review shall not be fewer than thirty (30) days, nor more than sixty (60) days from the date of receipt of request for appellate review, except that when the Affected Practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements may reasonably be made, but not more than thirty (30) days from the date of receipt of such request.

10.16.5. Appellate Committee. The appellate review shall be conducted by the Governing Body or a duly appointed appellate review committee of the Governing Body of no fewer than three (3) Members.

10.16.6. Conduct of the Appeal. The Governing Body or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings and shall consider the written statements of the parties submitted for the purpose of determining whether the Affected Practitioner has established by clear and convincing evidence that there has been a substantial failure to comply with the Medical Staff Bylaws during the course of the action which has materially prejudiced the Affected Practitioner or that the recommendation is arbitrary or unreasonable or is not supported by any reliable evidence. If oral argument is requested and permitted as part of the review procedure, the Affected Practitioner shall be present at such appellate review and shall be permitted to speak against the proposed Adverse Action. The Affected Practitioner shall answer questions of the appellate review body. The Medical Staff or the Governing Body, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the proposed Adverse Action, and who shall answer questions put to him/her by any member of the appellate review body. Both sides may be represented by counsel if they were so represented at the hearing.

10.16.7. Handling New Evidence. New or additional matters not raised during the original hearing or in the Hearing Committee report, nor otherwise reflected in the record, shall not be introduced at the appellate review unless good cause is shown as to why it was not presented at the hearing. The Governing Body or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters will be accepted.

10.16.8. Decision.

(a) If the appellate review is conducted by the Governing Body, it may affirm, modify, or reverse the proposed Adverse Action, or in its

discretion, refer the matter back to the Medical Executive Committee for further review and recommendation within fifteen (15) days. Such referral may include a request that the Medical Executive Committee arrange for a further hearing to resolve specified disputed issues.

(b) If the appellate review is conducted by a committee of the Governing Body, such committee shall, within thirty (30) days after the adjourned date of the appellate review, either make a written report recommending that the Governing Body affirm, modify, or reverse the proposed Adverse Action, or refer the matter back to the Medical Executive Committee for further review and recommendation within fifteen (15) days. Such referral may include a request that the Medical Executive Committee arrange for a further hearing to resolve disputed issues. Within thirty (30) days after receipt of such recommendation after referral, the committee shall make its recommendation to the Governing Body as above provided.

10.16.9. Conclusion. The appellate review shall not be deemed to be concluded until all the procedural steps provided in the Bylaws have been completed or waived. Upon completion of the procedural steps, the Chair of the Governing Body or the presiding chair of a committee appointed by the Governing Body may, through written notice to the parties, deem the appellate review to be concluded. If the Governing Body or committee takes no action to conclude the appellate review, the review shall be determined to be concluded no later than fifteen (15) days after the completion of the procedural steps required by these provisions.

Section 10.17. Final Decision of Governing Body.

10.17.1. Time Frame. Within thirty (30) days after the conclusion of the appellate review, the Governing Body shall make its decision in the matter and shall send notice thereof to the Affected Practitioner, by secure electronic email. If this decision is contrary to the Medical Executive Committee's last such recommendation, the Governing Body shall refer the matter to the dispute resolution process for further review and recommendation within fifteen (15) days and shall include in such notice of its decision a statement that a final decision will not be made until the dispute resolution process between the Governing Body and the Medical Executive Committee has concluded. At its next meeting after conclusion of the dispute resolution process, the Governing Body shall make its final decision with like effect and notice as provided above.

10.17.2. One Hearing and One Appeal. Notwithstanding any other provision of these Bylaws, no Affected Practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Medical Executive Committee, or by the Governing Body, or by a duly authorized committee of the Governing Body, or by both.

10.17.3. Reporting Requirements. The Hospital or its authorized representative shall report to the applicable state professional authority and National Practitioner Data Bank all Final Adverse Actions and certain resignations or surrenders of clinical privileges as required by the Indiana Hospital Statute and the Health Care Quality Improvement Act of 1986. The Governing Body's adoption of such Final Adverse Action shall occur after the hearing and appeal process set forth in these Bylaws has been completed or waived. Any precautionary suspension will be reported when required by state and federal law. For reporting purposes, a precautionary suspension is synonymous with the term "summary suspension" used in state and federal statutes and regulations.

ARTICLE 11 - DEPARTMENTS

Section 11.1. Departments. The Medical Staff does not have any medical staff departments.

ARTICLE 12 - MEDICAL DIRECTOR

Section 12.1. Officers. The sole officer of the Medical Staff shall be Medical Director who serves as the President of the Medical Staff. Whenever the Medical Director is immediately unavailable and cannot fulfil his Medical Staff President duties, his designee who must be a member of the Medical Executive Committee may carry out such duties.

Section 12.2. Qualifications. The Medical Director, must be a physician licensed in the State of Indiana, an Active Member of the Medical Staff of the Hospital and satisfy any additional requirements as determined by the Governing Body.

Section 12.3. Conflict of Interest Disclosure. The Medical Director shall disclose in writing to the Governing Body those personal, professional, or financial affiliations or relationships of which the Medical Director are reasonably aware could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff of the Hospital.

Section 12.4. Medical Staff President Duties. The duties shall include, but not be limited to:

(a) enforcing the Medical Staff Bylaws, Policies, and the state and federal laws and regulations as they may apply to Members of the Medical Staff, Privileged Practitioners of the Allied Health Practitioner Staff, and any other Privileged Practitioner;

(b) implementing corrective action indicated, and ensuring reasonable Medical Staff compliance with procedural safeguards in all instances where corrective action has been requested or initiated against a Member or a Privileged Practitioner;

(c) calling, presiding at, and being responsible for the agenda of all general Medical Staff and the Medical Executive Committee meetings;

(d) serving as chair of the Medical Executive Committee;

(e) serving as an ex officio member of all Medical Staff committees, without vote, unless membership on a committee is required by these Bylaws;

(f) interacting with Administration and Governing Body in all matters of mutual concern within the Hospital;

(g) appointing, in consultation with the Medical Executive Committee, committee members for all standing and special Medical Staff, liaison or multi-disciplinary committees, except where otherwise provided by these Bylaws and except where otherwise indicated, designating the chair of these committees;

(h) representing the views and policies of the Medical Staff to the Governing Body, Administration and Network;

(i) being a spokesperson for the Medical Staff in external, professional, and public relations;

(j) performing such other functions as may be assigned by these Bylaws, the Medical Staff, or the Medical Executive Committee; and

(k) serving on liaison committees with the Governing Body, Administration, or other medical staff officers of hospitals in the Network.

ARTICLE 13 - COMMITTEES

Section 13.1. Committee Designation. The committees described in this Article shall be the standing committees of the Medical Staff and where appropriate shall be structured to qualify as a "peer review committee" as set forth in the Indiana Peer Review Statute. Special or ad hoc committees may be created by the Medical Executive Committee to perform specific tasks. Medical Staff committees shall be responsible to the Medical Executive Committee. The Medical Staff may carry out medical staff responsibilities through participation in committees of the Hospital and the Network. 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.

Section 13.2. General Provisions.

13.2.1. Appointment. Unless otherwise specified in these Bylaws, members of all committees shall be appointed and may be removed by the Medical Staff President, subject to consultation with, and approval by, the Medical Executive Committee.

(a) Active Staff and Courtesy Staff Members shall be eligible for appointment to any committee of the Medical Staff established to perform one or more of the functions required by these Bylaws. Notwithstanding the above, only Active Staff Members are eligible to serve on the Medical Executive Committee.

(b) Where specified in these Bylaws, or where the Medical Executive Committee deems it appropriate to the functions of a Medical Staff committee, representatives of the Allied Health Practitioner Staff

and various services of the Hospital, including, without limitation, Administration, laboratory, nursing, information management, and pharmacy services may be eligible for appointment to specific committees of the Medical Staff. Unless otherwise provided in these Bylaws, the Administrator or designee shall be a Member of all Medical Staff committees.

(c) Unless specified otherwise in these Bylaws, only Members of the Active Staff and Courtesy Staff may vote on Medical Staff committees.

13.2.2. Committee Chair. Unless specified otherwise in these Bylaws, the chair of each standing or special committee shall be appointed by the Medical Staff President, subject to the approval of the Medical Executive Committee, for a term of two (2) years.

13.2.3. Terms of Committee Members. Unless otherwise specified in these Bylaws, each medical staff committee member shall be appointed to a committee for a term of two (2) years and may be reappointed as often as the Medical Staff President may deem advisable.

13.2.4. Removal. Unless otherwise specified in these Bylaws, the committee member may be removed by the Medical Staff President, subject to consultation with, and approval by, the Medical Executive Committee or automatically removed if the committee member ceases to be a Member in good standing or suffers a loss or significant limitation of clinical privileges.

13.2.5. Vacancies. Unless otherwise specified in these Bylaws, vacancies on any committee shall be filled in the same way an original appointment to such committee is made. If an individual appointed by the Medical Staff President is removed for cause, then the successor may be selected by the Medical Staff President.

13.2.6. Meetings. Unless otherwise specified in these Bylaws, committees will meet as needed at the discretion of the chair. At the discretion of the chair, committee members may be allowed to participate in meetings through electronic means, so long appropriate measures are taken by participants to preserve confidentiality.

13.2.7. Minutes. Unless otherwise specified in these Bylaws, all Medical Staff committees shall create and maintain minutes which shall be forwarded to the Medical Executive Committee for review and further follow up as appropriate.

13.2.8. Standing Committees. The standing committees are Medical Executive Committee, Bylaws Committee, Pharmacy and Therapeutics Committee, Health Information Management, and the Quality Improvement Committee

13.2.9. Special Committees. Special Committees shall be appointed by the Medical Staff President unless stated otherwise in these Bylaws, from time to time, as may be required to properly carry out the duties of the Medical Staff. Such committees shall confine their work to the purposes for which they were appointed and shall report to the Medical Executive Committee. A Special Committee shall not have power of action unless it is specifically granted by the motion which created the Special Committee or is authorized in the Bylaws. Special Committees include the Nominating Committee, and Ad Hoc Investigation or Hearing Committee.

13.2.10. Committee Members. Non-Physician members of committees shall be selected by the Administrator with the concurrence of the Medical Director. All committee participants shall agree to maintain the confidentiality of all committee matters.

Section 13.3. Medical Executive Committee.

13.3.1. Composition. The committee shall be comprised of all Active Staff category members of the Medical Staff who shall have the authority to vote on matters presented before the committee. All Courtesy Staff members and Allied Health Practitioner Staff members who shall not have the authority to vote on matters presented before the committee. The Administrator, the Director of Quality and the Nurse Executive may attend ex-officio with no voting privileges. The Medical Executive Committee may utilize Peer Review Personnel and invite guests to the meeting from time to time to provide information. Except for Peer Review Personnel, no guest will be allowed to attend any portion of the deliberations of the committee when exercising its peer review authority. The Medical Executive Committee shall fill any vacancy occurring in the committee during the period of the calendar year with an interim appointment if the original appointment was made through an election and no vice chair exists.

13.3.2. Responsibilities. The responsibilities of the Medical Executive Committee shall include but not be limited to:

(a) coordinate and implement the professional and organizational activities and general policies of the Medical Staff.

(b) receive and act upon reports and recommendations from Medical Staff, committees and assigned activity groups.

(c) recommend action to the Governing Body on at least the following:

i. individuals seeking Medical Staff Membership.

ii. delineation of clinical privileges for practitioners seeking clinical privileges through the Medical Staff process.

iii. the review of and actions on reports of the Medical Staff committees, and other assigned activity groups.

iv. the structure of the Medical Staff.

(d) the mechanism used to review credentials and to delineate clinical privileges.

(e) the organization of the quality improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities.

(f) the mechanism by which Medical Staff Membership may be terminated.

(g) the mechanism for fair hearing and appeal procedures.

(h) Participate in the development of all Medical Staff and applicable Hospital policies, practices, and planning with the authority to interpret these Bylaws and Policies when forming and enforcing Medical Staff Policies. Such policy, statements, or interpretations shall be communicated to the general Medical Staff.

(i) Consult with Hospital senior management on quality related aspects of contracts for patient care services with entities outside of the Hospital.

(j) Oversee all Peer Review activities on behalf of the Medical Staff of the Hospital which may include, but not be limited to:

i. evaluation of patient care rendered.

ii. participate in the development of all Medical Staff and Hospital policy, practice, and planning.

(k) review the qualifications, credentials, performance and professional competence and character of Applicants and Privileged Practitioners and make recommendations to the Governing Body regarding Medical Staff appointments and reappointments, clinical privileges, and corrective action.

(l) take reasonable steps to promote competent clinical performance, ethical conduct and conduct that promotes the culture of improvement and safety on the part of all Members including the initiation of a participation in Medical Staff corrective action or review measures when warranted.

(m) Design such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to Medical Staff committees by the Medical Staff President.

(n) Report to the Medical Staff at each regular Staff meeting.

(o) Assist in obtaining and maintaining accreditation.

(p) Develop and maintain methods for the protection and care of patients and others in the event of internal and external disaster.

(q) Appoint such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff.

(r) Receive reports from the GMEC and the training programs on the performance of its Advanced Trainees, approve the Network GME protocols for Advanced Trainees, receive alerts to any performance concerns or matters that may threaten patient safety, and ensure Members supervising Advanced Trainees hold clinical privileges commensurate with their oversight activities.

(s) Conduct an annual review of the Bylaws, rules and regulations as well as Policies and Procedures to reflect current practice, national standards for patient care, and an efficient organization of the Medical Staff to perform its functions;

(t) recommend to the Board any changes deemed necessary or desirable in the Bylaws, rules and regulations;

(u) develop and implement rules and regulations to establish standards of patient care and ascertain that these rules and regulations are consistent with Medical Staff Bylaws, rules and regulations and with Corporation and Board policies; and

(v) act as the Medical Staff mechanism for documenting the required annual review of the Medical Staff Bylaws, rules and regulations, making at that time, any recommendations for change.

(w) Oversee Credentials Functions of the Medical Staff:

i. Review and evaluate the qualifications of each practitioner applying for initial appointment, reappointment or modification of membership and Clinical Privileges and, in connection therewith, obtain and consider the recommendation of the Medical Director.

ii. Submit required reports and information on the qualifications of each practitioner applying for appointment or Clinical Privileges including recommendations with respect to appointment, category, section affiliation, Clinical Privileges, and special conditions.

iii. Investigate, review and report on matters referred by the Medical Executive Committee regarding the qualifications, conduct, professional character or competence of any applicant or privileged provider.

iv. Submit periodic reports to the Board on its activities and the status of pending applications.

v. Recommend to the Board the Medical Executive Committee changes in credentialing policies and procedures, as well as recommendations for Bylaw changes.

13.3.3. Delegated Authority. The Active Staff Members may limit or expand the powers of the Medical Executive Committee at a special or regular meeting of the General Medical Staff with the vote of one-third (1/3) vote of the Active Staff Members present and eligible to vote.

13.3.4. Removal. Removal of Members of the Medical Executive Committee serving by virtue of their office shall be set forth in either Article 11 or 12. Removal of a Member of the Medical Executive Committee serving by virtue as a standing committee chair shall occur by the same process set forth in Section 12.13.

13.3.5. Voluntary Resignation. Members of the Medical Executive Committee 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;

(b) Loss of membership on the Active Staff category of the Medical Staff; or

(c) The Medical Executive Committee recommends to the Governing Body that the Member be subject to corrective action.

13.3.6. Meetings. The Medical Executive Committee shall meet as often as necessary to accomplish its functions, but at least six (6) times per year, maintain minutes of its proceedings and actions, and forward its minutes to the Governing Body. Members are expected to attend 50 % of all meetings unless excused for good cause. Members attending less than 25% of the meetings without good cause will automatically be deemed to have resigned from the Committee.

13.3.7. Special Meeting. The Medical Staff President may call special meetings of the Medical Executive Committee at any time. Such meetings may be held in person or through telephonic or electronic conferencing.

Section 13.4. Quality Improvement Committee.

13.4.1. Function. The Performance Improvement Function shall be carried out by the Quality Improvement Committee.

13.4.2. Responsibilities, Duties, and Authority. The responsibilities of the Quality Improvement Committee shall include, but not limited to:

(a) coordinate and integrate all performance assessment and improvement components of the Performance Improvement Program to reduce/eliminate duplications, omissions, inconsistencies and failure to effect change;

(b) require that all evaluations performed are objective (based on preset criteria or standards), are clinically rather than administratively

oriented, and are designed to identify important problems/patterns of care and performance. The committee, through the Quality Director, may assist in providing suitable clinically valid criteria for use in performance assessment and improvement activities;

(c) monitor the Performance Improvement Program to the extent that it is comprehensive, in that all Specialties/Units/Practitioners are evaluated through the system in place;

(d) The Board will assess the MEC and QIC effectiveness in assuring any corrective action needed;

(e) maintain a current written performance improvement plan;

(f) perform at least an annual evaluation of the performance improvement program to assure its comprehensiveness and effectiveness; and

(g) the committee should make a report to the Board at least quarterly, and at any time a significant quality-related problem exists.

13.4.3. Meetings. The QIC shall meet as often as necessary to accomplish its functions, but at least six (6) times per year.

Section 13.5. Pharmacy and Therapeutics Committee.

13.5.1. Composition. The Pharmacy and Therapeutics Committee is a committee consisting of Active Staff members from the medical staffs of each hospital affiliated with the Network. At minimum, one (1) Active Staff Member of the Medical Staff shall serve as a voting member of the committee. When possible, the Members shall consist of Members representing the Medical Staff. The Hospital shall also have an on-site pharmacist and food service provider serve on the committee as non-voting members. The chair of the committee shall be selected by a majority of the voting members.

13.5.2. Duties. The duties of the Pharmacy and Therapeutics Committee shall include, but not limited to:

(a) Assist in the formulation of professional practices and policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital.

(b) Collect, on a routine basis, information necessary to improve the use of drugs and resolve problems with their use.

(c) Advise the Medical Staffs and the Pharmaceutical Service on matters pertaining to the choice of available drugs.

(d) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.

(e) Develop and review a formulary or drug list for use in the Hospital on a periodic basis.

(f) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.

(g) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

(h) Maintain a record of all activities relating to Pharmacy and Therapeutics functions and submitting periodic reports and recommendations to the Medical Executive Committee for consideration and approval.

(i) Review high prescription frequency and untoward drug reactions caused by interaction with other drugs or by the patient's age, disability, or unique metabolic characteristics.

(j) Provide recommendations for optimal nutritional support to patients. The Committee will focus on nutrition-related policies and procedures affecting therapeutic diets, oral supplements, enteral tube feedings and parenteral nutrition. The Committee shall operate in a quality improvement capacity to identify and report significant variations in patterns of patient care related to nutritional support.

13.5.3. Meetings. The Pharmacy and Therapeutics Committee shall meet a minimum of ten (10) times a year, maintain minutes of its proceedings and actions, forward its minutes and recommendations to each affiliated hospital's Medical Executive Committee for consideration of approval. Members are expected to attend 75 % of all meetings unless excused for good cause.

Section 13.6. Utilization Management.

13.6.1. Composition. The Utilization Committee is a committee consisting of Active Staff members from the medical staffs of each hospital affiliated with the Network. At minimum, one (1) Member of the Medical Staff shall serve as a voting member of the committee. The Hospital shall also have representatives of Administration on the committee with no vote. The chair of the committee shall be selected by a majority of the voting members.

13.6.2. Responsibilities. The Utilization Committee will provide effective utilization management through the review of services furnished by the Hospital and its Members to patients enrolled in Medicare, Medicaid, or other payer programs as may be appropriate. The Committee will provide recommendations for compliance with appropriate Accreditation Body standards and, at least yearly, recommendations on the utilization plan for the approval of the Medical Executive Committee.

13.6.3. Meetings. The Utilization Committee will maintain minutes of its proceedings and actions, forward its minutes and recommendations to the Medical Executive Committee.

Section 13.7. Health Information Management Committee.

13.7.1. Function. The Health Information Management Committee shall be carried out by individual(s) designated by the Quality Improvement Committee.

13.7.2. Responsibilities. The responsibilities of the Health Information Management Committee shall include but not limited to:

(a) review and evaluate medical records objectively, using prescribed work sheets, to help assure that the records are adequate for:

i. continuity of care purposes;

ii. use in performance assessment and improvement activities; and

iii. assisting in protecting the legal interests of the patient, the Corporation, and the responsible Practitioner(s);

(b) address issues of medical record content, delinquency, and deficiency, and recommend needed actions, including corrective actions;

(c) establish the format of the medical record in concert with the Executive Director Health Information Management and Clinical Documentation Review Orders Committee (CDROC), and review all forms to be used in the medical record;

(d) review and recommend approval or not, of all policies, rules, and regulations relating to medical records;

(e) recommend any need retention and destruction of medical records, and participate in decisions for computerization of medical records data;

(f) develop or cause to be developed, and implement a uniform record review system that, over a reasonable period of time causes a representative sampling of the records of all Practitioners to be evaluated.

13.7.3. Meetings. The Health Information Management Committee shall meet as often as necessary but at least six (6) times a year.

Section 13.8. Infection Prevention Committee.

13.8.1. Composition. The Infection Prevention Committee is a committee consisting of Active Staff members from the medical staffs of each hospital affiliated with the Network. The voting members shall consist of Members

representing the specialties of internal medicine, surgery, maternal and child, pathology, family medicine, critical care medicine, and the infection prevention site leader of each hospital. It may include non-voting representatives of Administration and other services such as nursing, microbiology, dietary, central supply, environmental, pharmacy, and surgery. The chair shall be selected by the voting members of the committee.

13.8.2. Responsibilities. The responsibilities of the Infection Prevention Committee shall include but not be limited to:

(a) Developing a hospital-wide infection control program and maintaining surveillance over the program.

(b) Developing a system for reporting, identifying, and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data and follow-up activities.

(c) Developing and implementing a preventative and corrective program designed to minimize infection hazards including establishing, reviewing, and evaluating aseptic, isolation and sanitation techniques.

(d) Developing written policies defining special indications for isolation techniques.

(e) Coordinating action on findings from the medical review of the clinical use of antibiotics.

(f) Acting upon recommendations related to infection control received from the Medical Staff President, the Medical Executive Committee, Medical Staff Quality Committee, departments, and other committees; and

(g) Reviewing sensitivities of organisms specific to the facility.

13.8.3. Meetings. The Infection Prevention Committee will meet as often as necessary at the call of its chair, but at least four (4) times a year. It shall maintain minutes of its proceedings and actions, forward its minutes and recommendations to the Medical Staff Quality Committee and the Medical Executive Committee.

ARTICLE 14 - ANNUAL AND GENERAL MEDICAL STAFF MEETINGS

Section 14.1. Annual Meetings. The Medical Staff shall hold an annual meeting. At this meeting, the Medical Staff President and committees of the Medical Staff shall make such reports as may be desirable. Appointments to the Staff Office will be discussed at this meeting. The annual meeting may be held at a regular meeting.

Section 14.2. Regular Meetings.

14.2.1. General Medical Staff. The general meeting shall be held annually. The Medical Staff President shall preside at all general meetings of the Medical Staff. The sole objective of such meeting is improvement in the care and treatment of patients in the Hospital. Business of the Medical Staff will be conducted by the Medical Staff President. The Medical Staff President or designee is required to conduct business. All Members of the Medical Staff shall be encouraged to attend general Medical Staff meeting

Section 14.3. Special Meetings. Special meetings of the Medical Staff may be called at any time by the Medical Staff President, the Board, the Medical Executive Committee or at least one fourth of the Medical Staff Members. The Medical Staff President will call a special meeting within seven (7) days of his/her receipt of written request for same. The attendance of a Member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting

Section 14.4. Meeting Attendance. Notice of regular and special meetings of the general medical staff shall be electronically sent to the Members of the Medical Staff at least two days prior to the meeting and posted in the Hospital. The meeting minutes from the previous general staff meeting and any special meeting shall be posted at least two (2) days prior to the meeting by the medical staff office.

Section 14.5. Quorum. Unless stated otherwise in these Bylaws, the Members eligible to vote who are present at a regular or special meeting shall constitute a quorum. If a quorum exists, action on a matter is approved if the votes cast favoring the action exceed the votes cast opposing the action, unless a greater number is required by these Bylaws.

Section 14.6. Agenda. The order of business and agenda of general Staff meetings will be determined by The Medical Staff President. Peer review and evaluation of patient care and clinical performance will be on the agenda as well as reading and acceptance of the minutes of the last meeting, consideration of any old business to be completed, and any agenda items under new business.

Section 14.7. Action in Lieu of Meeting. Any action required or permitted to be taken by the Medical Staff may be taken without a meeting if the votes cast favoring the action exceed the votes cast opposing the action by written ballot to such action, unless a greater number is required by these bylaws. Such action by written ballot shall have the same force and effect as a vote taken at a meeting of the Medical Staff.

ARTICLE 15 - AMENDMENT PROCESS

Section 15.1. Medical Staff Initiation. The Medical Staff Bylaws may be amended as set forth in this Article. Such amendments may be initiated by the Medical Staff or the Governing Body.

15.1.1. Proposed amendments to these Bylaws may be requested by the Medical Staff President, the Administrator, or any Member eligible to vote. Any such proposed amendment shall be referred to the Medical Executive Committee which shall report on it at the next regular meeting, or at a special meeting of the

Medical Executive Committee called for such purpose. Following a favorable vote by the Medical Executive Committee, each Member eligible to vote will be sent the proposed amendments. If approved by the voting process described below, the proposed amendment will be forwarded to the Governing Body for consideration.

In addition to the process set forth above, the Medical Staff may directly consider a proposed amendment or repeal of a provision to these Bylaws upon the written request of at least twenty-five percent (25%) of the Members eligible to vote. Such proposal shall be distributed to the Members eligible to vote on amendments thirty (30) days in advance of the meeting at which the vote will be held. No less than ten (10) days prior to a vote on any proposed amendment, the proposed amendment will be communicated to the Medical Executive Committee for consideration, and any comments or recommendations forwarded to the Governing Body for consideration. The Governing Body will consider comments submitted about the proposed Amendment and respond to the Medical Executive Committee within sixty (60) days.

Any proposed amendments adopted shall be effective when approved by the Governing Body.

Section 15.2. Governing Body Initiation. Proposed amendments may be initiated by the Governing Body. At least thirty (30) days in advance of the meeting at which the Governing Body proposes to take final action thereon, a copy of each proposed amendment shall be distributed to the Medical Executive Committee, and each Member eligible to vote on amendments. Any comments or concerns of the Medical Staff, or Medical Executive Committee must be forwarded to the Governing Body at least ten (10) days in advance of the Governing Body meeting where the final action will be taken. Any amendments approved by the Governing Body also shall require approval by the Members eligible to vote as provided herein. The proposed amendments shall be sent electronically to those Members at least thirty (30) days in advance of the vote. Amendments so adopted shall be effective when approved by Members eligible to vote. If for any reason, the Medical Staff does not approve the Governing Body's resolution, it shall promptly notify the Governing Body of any recommended changes at the time of the denial. The Governing Body may initiate the dispute resolution process described in these Bylaws.

Section 15.3. Voting on Amendments. A vote on proposed amendments may occur either by written ballot at a meeting or by written or electronic balloting with or without a meeting in accordance with procedures prescribed by the Medical Executive Committee. All ballots must be marked in the affirmative or negative to be considered in any final vote count. Votes will be counted on the "count date" listed on each ballot. Ballots submitted after that time shall not be counted. The Members eligible to vote present at a regular or special meeting shall constitute a quorum. The affirmative vote of one-third (1/3) of such Members shall be required to approve the proposed amendment. No voting by proxy is allowed. An absentee ballot may be utilized only if requested in writing 14 days in advance of the election meeting and if the Member eligible to vote demonstrates in the written request good cause as determined in the sole discretion of the Medical Staff President. To be timely and counted, an absentee ballot must be delivered to the Medical Staff Office twenty-four (24) hours in advance of the election meeting and will not be opened or counted until those attending the election meeting have voted.

Notwithstanding the foregoing provision, the Medical Executive Committee may provide for a vote on a proposed amendment to take place without a meeting of the Members eligible to vote only when time is of the essence and does not allow a special meeting of the Active Staff to be called with at least thirty (30) days advance notice of the proposed amendment prior to a vote. The Medical Executive Committee may determine the procedures (1) to be appropriate and in the best interest of the Medical Staff under the circumstances; and (2) to provide reasonable opportunity for each Member eligible to vote on the proposed amendment to register his or her vote. Each Member eligible to vote may cast their vote on the proposed amendment via secure electronic ballot in a manner determined by the Medical Executive Committee. To be adopted, such proposed amendment must receive an affirmative vote of one-third (1/3) of the votes timely returned.

Section 15.4. Substantial Revisions. In the event amendments adopted in accordance with this Article substantially change these Bylaws provisions, each Member of the Medical Staff shall receive a copy of the final revised portions electronically.

Section 15.5. Technical Changes. The Medical Executive Committee may adopt technical changes to the Medical Staff Bylaws without an affirmative of the Members eligible to vote. Technical changes are, in the committee's judgment, clarifications consistent with reorganization or renumbering of material, or are needed due to punctuation, spelling, or other errors of grammar or expression. Such technical changes must be ratified by the Governing Body. Likewise, establishing departments does not require an affirmative one-third (1/3) vote of the Members eligible to vote.

Section 15.6. Adoption of the Bylaws. These Bylaws shall replace and supersede existing Bylaws and shall become effective when approved by the Medical Staff eligible to vote and the Governing Body. They shall, when adopted and approved, be equally binding on the Governing Body and the Medical Staff.

Section 15.7. Mandatory Review of Bylaws. The Medical Staff shall review these Bylaws at least triennially and recommend to the Governing Body any amendments as needed in accordance with this Article. Neither the Governing Body nor the Medical Staff shall unilaterally amend the Medical Staff Bylaws.

Section 15.8. Policies and Procedures. The Medical Staff shall adopt such Policies, including the Rules and Regulations, as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These Policies shall relate to the proper conduct of the Medical Staff organization activities as well as embody the level of practice that is to be required of each Privileged Practitioner. Such Policies shall be considered a part of the Medical Staff Bylaws. The Medical Staff delegates authority to the Medical Executive Committee to propose and adopt such Policies, subject to the limitations set forth below. The Medical Executive Committee will furnish to all Members eligible to vote, for review and comment, a written copy of any proposed Policy or any amendment thereon at least ten (10) days prior to the meeting of the Medical Executive Committee at which the matter will be considered for a vote. In the event there is a documented need for an urgent amendment to comply with law or regulation, the Medical Executive Committee may provisionally adopt, and the Governing Body may provisionally approve such urgent amendment without prior notification to

the Medical Staff. In such cases, the Medical Staff will be immediately notified by the Medical Executive Committee, and the Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. The Medical Executive Committee shall notify the Medical Staff of its approval of a Policy or any amendment thereon. Any such matter shall be submitted to a vote to all Members eligible to vote only upon the written petition of twenty-five percent (25%) of the Members eligible to vote, received within thirty (30) days following approval of the Policy or amendments thereon by the Medical Executive Committee. Such matter shall be considered at a special meeting of the Medical Staff. In addition to the above, the Medical Staff may directly adopt a Policy, or any amendment thereto, at any annual or special meeting, to the extent such action is requested upon written petition of at least twenty-five percent (25%) of the Members eligible to vote. Notice of such proposed Medical Staff action shall be given to the Medical Executive Committee by the Medical Staff President at least ten (10) days prior to the meeting at which such matter will be considered. Such changes shall become effective when approved by the Governing Body. Further, the Governing Body shall have the right to propose changes to such Policies, subject to approval by both the Medical Executive Committee and the Members eligible to vote as set forth above.

ARTICLE 16 - DISPUTE RESOLUTION

Section 16.1. Process with Medical Executive Committee. To the extent a conflict arises between at least twenty-five percent (25%) of the Medical Staff eligible to vote and the Medical Executive Committee on issues including, but not limited to, proposed adoption of or amendment to these Bylaws or Policies, the following dispute resolution process shall be followed as determined by the Medical Staff President and Administrator before either the Medical Executive Committee or the Medical Staff takes an action contrary to an action, proposed action or position of the other group.

(a) The Medical Staff President shall appoint at least two Medical Executive Committee members to represent the Medical Executive Committee. The at-large members of the Medical Executive Committee, in consultation with the Administrator, shall appoint at least two Active Staff Members who are not members of the Medical Executive Committee to represent the Medical Staff in connection with the dispute.

(b) Such appointed representatives shall meet in good faith to attempt to resolve the dispute.

(c) In the event the dispute has not been resolved after at least two meetings of the representatives over at least a thirty (30) day period, this dispute resolution process shall terminate, and the Medical Staff and the Medical Executive Committee may proceed to take such actions as are otherwise authorized by these Bylaws or applicable Policies.

Section 16.2. Process with Governing Body. To the extent a conflict arises between at least twenty-five percent (25%) of the Medical Staff eligible to vote or the Medical Executive Committee and the Governing Body on issues including, but not limited to, proposed adoption of or amendment to these Bylaws or Policies, the following dispute resolution process shall be followed as determined by the Medical Staff President and Chair of the Governing Body before

either the Medical Executive Committee or the Governing Body takes an action contrary to an action, proposed action, or position of the other group.

(a) The Chair of the Governing Body shall appoint at least two directors to represent the Governing Body. In the event that the conflict is with the Medical Executive Committee, the Medical Staff President shall appoint at least two Medical Executive Committee members to represent the Medical Executive Committee. In the event that the conflict is with at least twenty-five percent (25%) of the Members eligible to vote, the at-large members of the Medical Executive Committee will select at least two Members eligible to vote not on the Medical Executive Committee to represent the Medical Staff in connection with the dispute.

(b) Such appointed representatives shall meet in good faith to attempt to resolve the dispute.

(c) In the event the dispute has not been resolved after at least two meetings of the representatives over at least a thirty (30) day period, this dispute resolution process shall terminate, and the Medical Staff and the Governing Body may proceed to take such actions as are otherwise authorized by the corporate bylaws of the Hospital.

ARTICLE 17 - UNIFICATION

Section 17.1. Unification. This Article sets forth the process for the Medical Staff to follow if the Network and the Governing Body of Fairbanks Hospital, Inc elect to have our Medical Staff participate in a unified and integrated medical staff of the Network affiliated hospitals.

Section 17.2. Right to Accept. The medical staff of each separately licensed hospital has the right to accept or opt out of the Network's election to have a unified and integrated medical staff for its affiliated hospitals by a two-thirds (2/3) majority vote of the total votes cast by the Members eligible to vote and present. The Medical Staff election to accept or to opt out of the unified and integrated medical staff shall follow Article 15, Section 3 except that the only Members eligible to vote for or against unification are Active Staff Members who hold clinical privileges to practice on-site at the Hospital. In other words, Active Staff Members who only hold telemedicine privileges or Distant Site Telemedicine Privileges at the Hospital are not eligible to vote to accept or opt out of unification. Likewise, Courtesy Staff and Affiliate Staff, with or without voting prerogatives on other Medical Staff matters, are not eligible to vote to accept or to opt out of unification.

Section 17.3. Acceptance. If the Medical Staff accepts the unified and integrated medical staff structure, the Members holding clinical privileges at the Hospital will continue to be governed and operate under the current Medical Staff Bylaws until bylaws for the unified medical staff are adopted. Once established, the medical executive committee of the unified medical staff shall consider each hospital's unique circumstances; any significant differences in patient populations and services offered at each hospital; and establish and implement policies and procedures to make certain that the needs and concerns expressed by staff members of each hospital are given due consideration; and ensure that mechanisms are in place to make certain that issues localized to a particular hospital are duly considered and addressed.

Section 17.4. Right to Opt Out. The medical staff of each separately accredited hospital has the right to opt out of the unified and integrated medical staff by a two-third (2/3) majority vote of its Active Staff Members holding clinical privileges to practice on-site at the Hospital upon the written request of at least twenty-five percent (25%) of those Members. The Medical Staff election to opt out of the unified and integrated medical staff shall follow the petition and election provisions set forth in Article 15, Sections 1 and 3 except that the only Members eligible to vote for or against unification are Active Staff Members who hold clinical privileges to practice on-site at the Hospital. In other words, Active Staff Members who only hold telemedicine privileges or Distant Site Telemedicine Privileges at the Hospital are not eligible to vote for or against unification. Likewise, Courtesy Staff and Affiliate Staff, with or without voting prerogatives on other Medical Staff matters, are not eligible to vote to accept or to opt out of unification.

Section 17.5. Interval Between Acceptance or Opt-Out Elections. The Hospital may not hold a vote on acceptance or opt-out vote more than once every two (2) years.

ARTICLE 18 - DUES AND EXPENDITURES

Section 18.1. Dues. The annual dues of the Medical Staff shall be determined, from time to time, by the Medical Executive Committee. The Medical Staff shall be notified of any attempt to increase dues at least thirty (30) days in advance of the date the Medical Executive Committee will consider same. All Members shall be required to pay dues annually. Dues notices will be sent within the first quarter of the calendar year with payment required within 30 days from date of mailing. Members whose dues are delinquent at the end of the 60 days shall be suspended. Reinstatement shall be contingent upon payment of dues in arrears equal to two (2) times the annual dues assessment if the reinstatement is made within two (2) months following the suspension. Members, whose dues are still delinquent at the conclusion of the two (2) month reinstatement period (or 120 days past due) will be considered to have voluntarily resigned. Such Members may reapply to the Medical Staff upon payment of past dues and the initial appointment Application fee.

These Bylaws, when approved by the Medical Staff and adopted by the Board, will supersede any previously adopted Bylaws.

Approval:
Medical Executive Committee: 03/28/2023
General Medical Staff: 03/28/2023
Quality of Care: 04/11/2023
Board of Directors: 04/26/2023