UH PARMA MEDICAL CENTER
BYLAWS
OF THE
MEDICAL STAFF

<u>Approved by Board</u>
November 19, 2025

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PREAMBLE

University Hospitals Parma Medical Center, a wholly-owned subsidiary of University Hospitals Health System, Inc. ("UH"), is a nonprofit corporation organized under the laws of the State of Ohio. Its purpose is to serve as a general hospital providing patient care, education, and research. It is recognized that the Medical Staff is responsible for the quality of medical care in the hospital, and must accept and discharge this responsibility. The Medical Staff and these Medical Staff Bylaws are subject to the ultimate authority of the hospital governing body.

University Hospitals Health System, Inc. is an Ohio nonprofit corporation and a public benefit corporation. Its role and purpose is to (1) maintain, manage, oversee and set policy for a multi-entity health care delivery system (the "System") that includes hospital, out-patient, home care, research, educational and related facilities, (2) provide administrative and management expertise and services to the health care delivery entities within the System, (3) encourage, promote and support the functions, operations and purposes of the health care delivery entities within the System, and (4) to encourage, promote and support the carrying out of research, study and education, including medical and nursing education.

The physicians practicing in the Hospital hereby organize themselves into a Medical Staff in conformity with these Medical Staff Bylaws.

DEFINITIONS

The following definitions apply to the provisions of these Bylaws of the Medical Staff:

ADMINISTRATION refers to the Hospital President and other Officers within the General Administration of Hospital.

ALLIED HEALTH PROFESSIONALS (AHP) refers to certified nurse anesthetists, physician assistants, licensed independent social workers, and others as approved by the Board, authorized to provide clinical services in the Hospital who may or may not be Hospital employees, who are not members of the Medical Staff, but who are employed by and/or supervised by an Active member, in good standing, of the Medical Staff who is in the same specialty.

BOARD OF DIRECTORS (or BOARD) means the Board of Directors of Hospital, and its subcommittees, including the Quality & Professional Affairs Committee, as authorized by the Hospital Code of Regulations which acts as the Hospital's governing body.

BYLAWS refer to these Medical Staff Bylaws.

CHIEF MEDICAL OFFICER (CMO) refers to the UH appointed Chief Medical Officer of the Hospital or his or her designee; this term is from time to

time used interchangeably with, and is equivalent to, the Vice President of Medical Affairs ("VPMA");

ELECTRONIC NOTICE means notification sent by email to an email address provided by the recipient to the UH Credentialing Department (UHCD)**.**

HOSPITAL refers to University Hospitals Parma Medical Center.

HOSPITAL PRESIDENT refers to the President of the Hospital.

LICENSED INDEPENDENT AFFILIATE HEALTH CARE PRACTITIONER (LIAP) refers to clinical nurse specialists, nurse practitioners, and others as approved by the Board of Directors, authorized to independently practice or provide clinical services in the Hospital who may or may not be Hospital employees, who are not members of the Medical Staff, but who are employed by and/or in collaboration with an Active member, in good standing, of the Medical Staff who is in the same specialty.

MEDICAL STAFF refers to duly licensed physicians, dentists, oral and maxillofacial surgeons, podiatrists, psychologists, and other licensed independent practitioners as defined by the Medical Executive Committee and Board of Directors, including members of the Active, Courtesy, Associate, and Honorary categories of the Medical Staff of Hospital and who (except for Honorary Staff) participate in the care of patients, teaching and/or research at Hospital.

MEMBER refers to a member of the Medical Staff.

NOTICE means written notification.

POLICIES AND PROCEDURES refers to the Policies and Procedures of Hospital, its clinical departments, its Medical Staff, and University Hospitals Health System.

RULES AND REGULATIONS refers to the Rules and Regulations of the Medical Staff of Hospital.

I. NAME

The name of this organization shall be the Medical Staff of University Hospitals Parma Medical Center.

II. PURPOSES AND RESPONSBILITIES

A. PURPOSES: The purposes of the Medical Staff shall be to:

1. Facilitate the provision of quality medical care to Hospital patients regardless of race, color, religion, creed, religion, gender, sexual orientation,

national origin, marital or family status, presence of any disability, age, ancestry, veteran's status or financial resources.

2. Ensure that the same level of quality patient care is provided by all individuals with delineated clinical privileges on the Medical Staff and across departments.

3. Achieve and maintain the highest possible level of professional performance by all Members and other individuals with clinical privileges through the credentialing process, the delineation of clinical privileges and the peer review and quality assurance processes.

4. Provide quality medical care consistent with available resources to all patients admitted to or treated in the Hospital.

5. Develop and adopt Bylaws and Rules and Regulations to establish a framework for the self-governance of the Medical Staff.

6. Provide a means by which issues concerning the Medical Staff, other individuals with delineated clinical privileges and the Hospital may be discussed and resolved.

7. Provide the formal organizational structure through which the benefits of membership on the Medical Staff may be obtained by individual practitioners and through which the obligations of Medical Staff membership may be fulfilled.

8. Serve as the primary means for accountability to the Board for the appropriateness of the professional, ethical or clinical conduct of Members and other individuals with delineated clinical privileges.

B. RESPONSIBILITIES: The responsibilities of the Medical Staff shall be to:

1. Account for the quality of patient care rendered by all Members and other individuals with delineated clinical privileges authorized to practice in the Hospital by:

a. Making recommendations to the Board for appointment, reappointment, and granting of clinical privileges;

b. Maintaining a continuing education program that contributes to an ongoing quality assurance effort and identifies and responds to patient care needs;

c. Creating and maintaining an organizational structure that provides for regular monitoring of patient care practices and measuring the performance of patient care processes;

d. Designing, monitoring, assessing and improving the effectiveness, availability, timeliness, appropriateness, accessibility, continuity, efficiency and safety of patient care and respect for patients.

2. Account to the Board for the quality and continuity of patient care.

3. Account for compliance with Hospital requirements regarding completion and documentation of medical histories and physical examinations (H&P), as detailed in the UH Parma Medical Center Rules & Regulations

a. Completion of H&P.

i. Within 24 hours of and/or prior to surgery, invasive or non-routine procedure, administration of anesthesia or moderate/deep sedation.

ii. Performed no more than 30 days before the procedure. If more than 30 days, H&P repeated.

iii. Completed by physicians, oral and maxillofacial surgeons, advanced practice nurses, physician's assistants, and house staff.

b. Documentation of H&P

i. Copy of H&P shall be in patient's medical record.

ii. H&P update shall be documented for H&P performed prior to admission; within 24 hours of admission; prior to a major diagnostic or therapeutic intervention; if no changes to the initial H&P.

c. H&P consists of:

i. Medical history including chief complaint, details of present illness, co-morbidities and relevant social and family histories

ii. Physical exam including inventory by body system; assessment of physical, psychological, and social needs.

iii. Conclusions or impressions drawn from H&P

iv. Diagnosis

d. Emergency situations: relevant parts of H&P must be documented prior to an emergency procedure, unless delay may compromise patient care.

4. Initiate and pursue peer review and corrective action with respect to Members and other practitioners when warranted.

5. Develop, administer, and seek compliance with these Bylaws, the Rules and Regulations, the University Hospitals Health System Compliance Program, and all applicable policies of the Hospital and University Hospitals Health System.

6. Assisting in identifying community health needs, setting appropriate institutional goals and implementing programs to benefit the community.

7. Exercising the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.

III. MEDICAL STAFF MEMBERSHIP

A. MEMBERSHIP

1. Membership on the Medical Staff of the Hospital is a privilege extended by the Hospital and is not a right of any physician, practitioner, or other person. Membership shall be extended only to those individuals who continually meet the qualifications, standards and requirements set forth in these Bylaws. Membership may be with or without admitting and/or clinical privileges. Appointment to the Medical Staff shall be limited to the needs of the patient population served by the Hospital as determined by the Board after recommendation by the appropriate Chair and Medical Executive Committee. No person shall be automatically entitled to Staff membership or to the exercise of clinical privileges simply by virtue of the fact that he/she is licensed to practice within his/her health care profession, is a member of a professional organization, is certified by any board, or has or in the past had Medical Staff membership or clinical privileges at any other hospital or health care organization.

2. ELIGIBILITY

a. Only physicians, dentists, oral and maxillofacial surgeons, podiatrists, psychologists, and other licensed or registered practitioners (as defined by the Medical Executive Committee) shall be considered for membership on the Medical Staff. House staff are not members of the Medical Staff.

b. No applicant shall be entitled to membership on the Medical Staff solely by virtue of the fact that the individual is: licensed/registered/certified to practice in the State of Ohio or in any other state; a participating provider in any managed care

organization or network; a member of any professional organization; certified by any clinical board; presently holds or formerly held Medical Staff membership or clinical privileges at the Hospital or with another health care organization.

c. Membership will neither be granted nor denied on the basis of race, color, religion, creed, gender, sexual orientation, national origin, marital or family status, age, ancestry, or veteran's status.

d. Applicants for membership on the Medical Staff shall demonstrate to the Medical Staff and the Board that they will provide care to patients at least at the generally recognized professional level of quality.

e. Requirements for membership on the Medical Staff shall include the following:

i. Current licensure/registration/certification in good standing in the State of Ohio (except for Members of the Honorary Staff) with the same legal name as set forth on the Member's application for membership on the Medical Staff;

ii. Current ability to participate in Medicare, Medicaid and all other applicable federal or state healthcare programs, without any limitations, restrictions, sanctions, or exclusions;

iii. Successful completion of an accredited residency training requirement in the United States, if any, as defined by the individual clinical departments on the applicable departmental privilege delineation form, and as approved by the Medical Executive Committee and Board;

iv. Board Certification requirements: Provide documentation of board certification in his/her primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties ("ABMS"), the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, the American Board of Podiatric Surgery, or the American Board of Professional Psychology, as applicable in accordance with the following::

1) In the case of memberships granted after January 1, 2014, a Physician, Podiatrist, or

Dental Specialist who is a qualified candidate for board certification at the time of initial application for Medical Staff appointment and/or Privileges shall have the time period, as set by the applicable certifying board, following the date of completion of residency or fellowship training to become board certified. If the applicable certifying board does not specify a time period for board certification, the Physician, Podiatrist, or Dental Specialist shall have five (5) years following the date of completion of training to become certified.

2) All other applicants must be board certified in their respective specialty upon appointment and throughout the duration of their Medical Staff membership.

3) Failure to maintain continuous certification, including any Maintenance of Certification requirement, will result in the voluntary relinquishment of Medical Staff privileges, which would not be subject to the appeal process under Section XI.

4) Practitioners who were members of the Medical Staff as of January 1, 2014, who were not board certified as of that date, and who have continuously held their Medical Staff appointment since that time are exempt from this requirement.

5) The Board may, in its discretion and after consultation with the Medical Executive Committee, CMO and appropriate chairman, grant exceptions to this requirement.

v. For Psychologists: Psychologist members of the Medical Staff must hold a doctoral degree in psychology and be fully licensed clinical psychologists by the State Board of Psychology of Ohio;

vi. For Dentists: Dentist members of the Medical Staff must hold a Doctor of Dental Surgery or equivalent degree and hold a valid and unsuspended license to

practice dentistry issued by the State Dental Board of Ohio;

vii. Current experience and demonstrated competence in each area of clinical privileges requested;

viii. Ability to perform all of the physical or mental health functions related to the specific clinical privileges requested as a Member, with or without accommodation;

ix. Strict adherence to professional ethics, the ability to work cooperatively and collaboratively with others and of willingness to participate in the discharge of Medical Staff responsibilities;

x. Evidence of current professional liability insurance as defined by Hospital policy;

xi. Evidence of current, unrestricted Drug Enforcement Agency (DEA) registration, valid in the State of Ohio, if Hospital prescribing privileges for controlled substances are requested;

xii. Compliance with the Hospital's Communicable Diseases Policy;

xiii. Compliance with the Hospital's Safety Policy;

xiv. Compliance with University Hospitals Health System Compliance Program and Guidelines;

xv. Compliance with these Bylaws, the Rules and Regulations and all other applicable policies of the Hospital and University Hospitals Health System; and

xvii. For Members with admitting privileges, demonstrated proficiency (to the satisfaction of the CMO) in the use of electronic medical records and/or similar technology.

f. By accepting membership on the Medical Staff, the Member agrees to:

i. Provide patient care at the generally-recognized professional level of quality and efficiency;

ii. Abide by the Bylaws, Rules and Regulations and by all other established standards, policies and rules of the Hospital and University Hospitals Health System;

iii. Discharge such Medical Staff, Department, Division, Committee and Hospital functions for which he/she is responsible by appointment, election or otherwise;

iv. Prepare and complete, in a timely and legible manner, but no later than thirty (30) days after a patient is discharged, the medical and other required records for all patients whom he/she admits or for whom he/she provides care in any way in the Hospital;

v. Abide by the University Hospitals Health System Compliance Program and by the ethical principles of his/her profession;

vi. Immediately notify the CMO and Hospital President of the following:

A) The revocation, suspension, or limitation of his/her professional license or DEA registration or any DEA schedules;

B) The imposition of terms of probation or limitation of practice by any State;

C) Imposition of any limitation, sanctions, restrictions or exclusion from participation in the Medicare, Medicaid or other applicable federal or state healthcare programs;

D) A material change in practice or his/her loss of staff membership or loss or restriction of privileges at any hospital or other health care organization;

E) Removal from the provider panel of any managed care organization or third party payor;

F) The commencement of a formal investigation, or the filing of charges, by the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or by any State or governmental authority;

G) The filing of a claim against the Member alleging professional liability, regardless of whether or not the claim relates to services provided at the Hospital;

H) Entering into or the existence of any material financial relationship or consulting agreement with

a medical supply company, device manufacturer or vendor;

I) Entering into a material financial relationship with a health system (or its controlled entity) not affiliated with University Hospitals Health System.

vii. Provide services to all patients regardless of their ability to pay;

viii. If requested, participate in teaching and/or research programs as conducted by the Hospital;

ix. Participate actively in performance and quality improvement initiatives of the Hospital;

x. Participate in the Hospital's safety program;

xi. Participate in educational or instructional programs deemed mandatory by the CMO, Chairs, Division Chiefs, and/or the Medical Executive Committee; and

xii. Participate in all applicable on-call coverage requirements as determined by Chairs, Division Chiefs or their designees in accordance with applicable laws, regulations and/or Hospital policies.

3. CONDITIONS AND DURATION OF APPOINTMENT

a. All Members are assigned to at least one clinical department with corresponding privileges and may be granted privileges in other clinical departments (except Members of the Honorary Staff who are granted no admitting or clinical privileges).

b. Appointment to the Medical Staff shall be made by the Board after receiving recommendations from the Medical Executive Committee and Department Chair. Medical Staff appointments shall be for a period of no longer than two (2) years. Members of the Active, Courtesy, and Associate Staffs are required to reapply for continued appointment and/or clinical privileges at least every two (2) years.

c. Each appointment or reappointment shall be valid for the period stated on the appointment or reappointment form, unless otherwise terminated or restricted as provided herein. Any change in

appointment status or clinical privileges shall apply only to the remainder of the then current appointment period.

d. Relinquishment of Clinical Privileges Due to Inadequate Utilization of the Hospital:

i. If a Member's Medical Staff appointment and/or clinical privileges are voluntarily relinquished due to failure to provide sufficient patient contact for a satisfactory evaluation in the reasonable discretion of the Medical Executive Committee, the Member shall be given written notice before a report of the voluntary relinquishment is made to the Medical Executive Committee.

ii. The Member shall have ten (10) days following his/her receipt of a notice to request a meeting with the Department Chair and the CMO. Such request shall be deemed to have been made when delivered to the CMO in person or when sent by certified mail, return receipt requested to the CMO. Failure of member to attend such meeting for whatever reason shall result in voluntary resignation from Medical Staff membership.

iii. At this meeting, which is in lieu of a hearing under Section XI of these Bylaws, the Member shall have an opportunity to explain or discuss extenuating circumstances involving his or her failure to provide sufficient patient contacts for a satisfactory evaluation.

iv. At the conclusion of the meeting, the CMO shall make a written recommendation to the Medical Executive Committee and the Board. The decision of the Board shall be final. Physician shall not be entitled to a fair hearing or appeal of this decision.

v. In lieu of voluntary resignation under this section, the Medical Staff Member may elect to have his/her clinical privileges modified to Courtesy/Refer-and-Follow privileges, as delineated by the Medical Executive Committee. Such modification shall be deemed voluntary, shall not give rise to due process rights under Section XI, and shall not be a reportable event to the State Medical Board or the National Practitioner Data Bank.

4. CATEGORIES OF THE MEDICAL STAFF

The categories of Medical Staff Membership shall include the following: Active, Courtesy, Associate, and Honorary. At the time of appointment or reappointment, the Member's staff category shall be determined and assigned.

a. Active Staff. The Active Staff shall consist of physicians, dentists, oral and maxillofacial surgeons, podiatrists and psychologists with or without admitting privileges to the Hospital. Psychologists shall not have admitting privileges. Podiatrists shall be able to co-admit with a physician. Members of the Active Staff may consult on and/or may treat both inpatients and outpatients, as determined by clinical privileges granted. Clinical privileges for psychologists are delineated through the clinical department where they hold their Medical Staff appointment. Active Staff may or may not have voting rights, depending on the terms of appointment.

i. *Qualifications*. The Active Staff shall consist of members, each of whom:

A) meets the general qualifications for membership set forth in Section IV;

B) has offices or residences in sufficient proximity to Hospital to provide adequate continuity of care based upon the criteria defined in the Rules and Regulations;

C) regularly cares for patients in the Hospital and utilizes Hospital as a principal site of hospital practice;

D) is certified by the recognized specialty board of the practitioner's field, if applicable; and

E) in order to qualify for Voting status, has met the additional requirements:

1) has satisfactorily completed at least one (1) year as an Active Staff member, and

2) has, for the previous calendar year, complied with the meeting attendance requirements set forth in Section IX.

ii. *Prerogatives*. The prerogatives of an Active Staff member shall be to:

A) exercise such clinical privileges as are granted pursuant to these Bylaws;

B) be the only Member who can vote on all matters presented at general and special meetings of the Medical Staff, subject to the terms of his/her appointment and subject to the meeting attendance requirements of Section IX; and

C) hold staff, division or department office and serve as chair or a voting member of committees to which he/she is duly appointed or elected by the Medical Staff or a duly authorized representative thereof.

b. Courtesy Staff. The Courtesy Staff shall consist of physicians, dentists or oral and maxillofacial surgeons, podiatrists and psychologists without admitting privileges at the Hospital. A Courtesy Staff appointment consists primarily of consultation and follow-up privileges. These members, in most cases, have their primary appointments at another area hospital. They are only permitted to act as consultants for inpatients. Clinical privileges are delineated accordingly.

i. *Qualifications*. The Courtesy Staff shall consist of Members, each of whom:

A) meets the general qualifications for membership set forth in Section IV;

B) has offices or residences which are located in sufficient proximity to Hospital to provide adequate continuity of care based upon the criteria defined in the Rules and Regulations;

C) understands and is willing to abide by any limitations which may be placed upon the courtesy privileges being granted to the Member; and

D) is granted clinical privileges depending on the qualifications, training, type of practice and licensure of the individual. These factors shall be considered when making regular reappointments and assignments.

ii. *Prerogatives*. The prerogatives of a Courtesy Staff member shall be to:

A) exercise such clinical privileges as are granted to the Member pursuant to Section IV of these Bylaws; and

B) attend meetings of the combined Medical Staff and the department and service to which the Member is assigned, and any combined staff or Hospital educational programs, but the Member shall be without voting privileges except on any committee to which the Member is appointed.

c. Associate Staff. The Associate Staff shall consist of independently licensed or State registered practitioners who hold clinical privileges. Associate Staff includes optometrists , nurse midwives, or other professionals that the Medical Executive Committee may designate. Clinical privileges are delineated through the department where the individual holds privileges.

i. *Qualifications*. The Associate Staff shall consist of members, each of whom:

A) meets the general qualifications for membership set forth in Section IV;

B) has offices or residences which are located in sufficient proximity to Hospital to provide adequate continuity of care based upon the criteria defined in the Rules and Regulations; and

C) regularly cares for patients in the Hospital or is regularly involved in Medical Staff functions.

ii. *Prerogatives*. The prerogatives of an Associate Staff member shall be to exercise such clinical privileges as are granted pursuant to Section IV of these Bylaws. Associate Staff do not have admitting privileges.

d. Honorary Staff. The Honorary Staff shall consist of physicians, dentists, oral and maxillofacial surgeons, podiatrists, and psychologists who have voluntarily retired from practice but desire to maintain their affiliation with the Hospital and are recommended by their Chair for this status. No admitting or clinical privileges are granted.

i. *Qualifications*. The Honorary Staff shall consist of members recognized for their contributions to the health and medical sciences, or their previous long-standing service to the Hospital. The Credentials Committee may consider an Active Staff member for Honorary Staff privileges, upon the staff Member's request, in the event that:

A) The CMO or the Hospital President receives notification of the active staff member's retirement; or the active staff member discontinues admission or consultations for over twelve (12) months, and is otherwise in good standing.

ii. *Prerogatives*. Honorary Staff members are not eligible to admit patients to the Hospital. They may attend staff, department, and service meetings and any staff or Hospital education meetings. Honorary Staff members shall not be eligible to vote or to hold office in this Medical Staff organization, or its committees, and shall be exempted from paying Medical Staff dues and assessments.

5. EXCEPTIONS TO PREROGATIVES.

Regardless of the category of membership on the Medical Staff, unless otherwise required by law:

a. Only Active Staff may vote on matters within the scope of their licensure or certification. In the event of a dispute over voting rights, that issue shall be determined by the Chair of the meeting subject to final decision by the Medical Executive Committee; and

b. Members should exercise clinical privileges only within the scope of their licensure or certification as set forth in these Bylaws and the laws of the State of Ohio.

c. The prerogatives set forth under each staff category are general in nature and may be subject to limitation by special conditions attached to Members' privileges, by other Section of these Bylaws, and by other policies of the Hospital.

6. MODIFICATION OF MEMBERSHIP CATEGORY

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a member under Section IV, the Medical Executive Committee may recommend to the Board a change in the Medical Staff category of a member consistent with the requirements of these Bylaws.

7. CONTRACTUAL RELATIONSHIPS.

The appointment and/or clinical privileges of any Medical Staff Member or other practitioner who has a contractual relationship with the Hospital, or is either an employee, partner, or principal of, or in, an entity which has a contractual relationship with the Hospital relating to providing services to patients at the Hospital, are defined through Medical Staff mechanisms.

a. These privileges shall terminate automatically and immediately, unless the contract specifies otherwise, upon

i. the expiration or other termination of the contractual relationship with the Hospital; or

ii. the expiration or other termination of the relationship of the Medical Staff member or other practitioner with the entity that has a contractual relationship with the Hospital.

b. For members of the Medical Staff, such termination shall be considered a voluntary resignation.

c. In the event of such termination of Medical Staff appointment and/or clinical privileges or other contractual relationship with the Hospital, there shall be no rights to a hearing or appellate review as provided in Section XI of these Bylaws.

B. LICENSED INDEPENDENT AFFILIATE HEALTH CARE PRACTITIONERS (LIAPs) AND ALLIED HEALTH PROFESSIONALS (AHPs)

1. Permission to practice in the Hospital as an LIAP or AHP is a privilege which shall be extended only to those individuals who have successfully completed the application process, been approved for specific clinical privileges, continually meet the qualifications, standards, requirements, and competencies set forth in the applicable LIAP/AHP Policy and shall be limited to the needs of the patient population served by the Hospital as determined by the Board of Directors.

2. The LIAP/AHP Staff shall consist of LIAPs, AHPs, or other State licensed practitioners who hold clinical privileges. Clinical privileges are delineated through the department where the individual holds privileges. LIAP/AHP practitioners are required to reapply for continued clinical privileges at least every two (2) years. Such practitioners are not Medical Staff members and are not required to attend Medical Staff meetings. They may or may not have admitting privileges.

a. *Qualifications*. The LIAP/AHP Staff shall consist of members, each of whom:

i. meets the general qualifications for membership set forth in Section IV;

ii. has offices or residences which are located in sufficient proximity to Hospital to provide adequate continuity of

care based upon the criteria defined in the Rules and Regulations; and

iii. regularly cares for patients in the Hospital or is regularly involved in Medical Staff functions.

b. *Prerogatives*. The prerogatives of an LIAP/AHP Staff member shall be to exercise such clinical privileges as are granted pursuant to Section IV of these Bylaws.

IV. APPOINTMENT AND REAPPOINTMENT

A. GENERAL

Except as otherwise specified herein, no individual (including individuals engaged by the Hospital in administratively responsible positions) shall exercise privileges in the Hospital unless and until the individual applies for and receives appointment to the Medical Staff or is granted temporary privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment (or, in the case of members of the Honorary Staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these Bylaws, the Rules and Regulations, the Hospital corporate Bylaws and summaries of other applicable policies relating to clinical practice in the Hospital, if any, and agrees that throughout any period of membership the applicant will comply with the responsibilities of Medical Staff membership and with the Bylaws and the Rules & Regulations as they exist and as they may be modified from time to time and with all other applicable policies and procedures of University Hospitals Health System. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws.

B. BURDEN OF PRODUCING INFORMATION

In connection with applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of producing, by clear and convincing evidence, sufficient information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, and/or resolving, by clear and convincing evidence, any doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. This burden may include submission to a medical or psychiatric examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee or the Board either of which, as the case may be, may select the examining physician.

C. APPOINTMENT AUTHORITY

The Board shall be the appointment authority. Appointments, denials and revocations of appointments to the Medical Staff shall be made as set forth in these Bylaws, but only after there has been a recommendation from or an untimely failure to act by the Medical Staff. The Board may act on the recommendation of the Medical Staff if they agree; otherwise they may act based on their own decision.

D. CREDENTIALING VERIFICATION

1. The Hospital may utilize a credentialing verification organization ("CVO") in addition to or in lieu of performing its own verification. The applicant's consent for this Hospital to credential the applicant to its Medical Staff shall be deemed authorization to process the applicant's information through such an organization pursuant to an agreement between the Hospital and that organization.

2. CONDITIONS OF APPLICATION.

By applying for appointment and clinical privileges to the Medical Staff, the applicant:

a. Agrees, if requested, to appear for interviews in regard to his/her application;

b. Agrees to produce sufficient information and/or appear for verification of personal identity;

c. Authorizes Hospital representatives to consult with others who have been professionally associated with him/her;

d. Consents to the inspection by Hospital or its designee of all records and documents pertinent to his/her qualifications for Medical Staff membership;

e. Consents to the release of any information pertaining to his/her professional competence or professional conduct to any UH wholly-owned entity where he/she is privileged or is seeking privileges, both during the application process and throughout the duration of his/her appointment;

f. Releases from liability the Hospital, its affiliates, its agents, employees and representatives for their acts performed and statements made in good faith in connection with evaluating the applicant and his/her credentials;

g. Releases from all liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives in good faith concerning the applicant's ability, professional ethics, character, ability to

perform any of the physical or mental health functions related to the specific clinical privileges requested of a member of the Medical Staff, with or without accommodation and other qualifications for Medical Staff appointment and clinical privileges;

h. Agrees that any lawsuit brought by the applicant against an individual or organization providing information to a Hospital representative, or against a Hospital representative, shall be brought in a court, Federal or State, in the state in which the defendant resides or is located;

i. Agrees to submit any reasonable evidence of current health status that may be requested by Medical Staff Office, Medical Executive Committee, or either's designee;

j. Is required to submit a completed Request for Application as a prerequisite to any processing of an application for initial appointment; and

k. Is required to submit a complete appointment application.

2. INITIATION OF THE APPLICATION PROCESS.

Applicants shall initiate a request for appointment and clinical privileges at Hospital by contacting the Hospital's Medical Staff Office and requesting the application materials for a Medical Staff appointment.

i. Prerequisite. All applicants will receive a Request for Application Processing form with the application packet sent by Hospital in which the applicant will be required to describe in detail all financial relationships, if any, that the applicant has with a health system(s) (or its controlled entity) not affiliated with University Hospitals Health System.

E. APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

A complete application for membership shall be submitted to the Medical Staff Office and shall contain the following:

1. completed Request for Application form;

2. completed application form consisting of the credentialing application form prescribed by the Ohio Department of Insurance and the University Hospitals Health System Application for Initial Credentialing;

3. current demographic information;

4. description of education, training, professional experience, current and all former licensure, and other qualifications;

5. narrative, written explanation of all gaps in work history greater than two months;

6. information regarding any former or current professional liability or malpractice actions, including but not limited to litigation, arbitration or mediation, regardless of status, method or outcome;

7. information regarding whether the applicant's professional license or controlled substance registration (federal DEA), in any jurisdiction, has ever been the subject of or is the subject of a disciplinary action, restriction, revocation, suspension or limitation of any kind and whether voluntary or involuntary relinquishment or limitation of such licensure or registration has occurred;

8. any voluntary or involuntary termination or denial of Medical Staff membership, or limitation, reduction, or loss of clinical privileges or employment at any other health care organization;

9. information regarding any physical or mental condition which could affect the ability of an applicant to exercise the clinical privileges requested or would require an accommodation in order to exercise the requested privileges safely and competently;

10. any history of state or federal criminal charges or convictions;

11. signed Condition of Application/Release and Immunity Statement;

12. a list all current and previous State license(s) to practice and registration numbers;

13. evidence of valid DEA registration and signed DEA pharmacy cards (excepting members of the Department of Pathology, psychologists, members of the Medical Staff who do not prescribe controlled substances in their practice, and Honorary Medical Staff);

14. professional liability history and current certificate of insurance coverage showing effective and expiration dates, individual coverage limits and named insured;

15. evidence of board specialty certification (if applicable), as indicated on the privilege delineation form, as established by department policy;

16. copy of current curriculum vitae;

17. completed privilege delineation form corresponding to staff category as defined by these Bylaws;

18. any documentation needed to support the request for clinical privileges that require special training or experience (as indicated on the privilege delineation forms or as established by department policy);

19. signed Medicare attestation statement;

20. proof of compliance with the Hospital's Communicable Diseases Policy;

21. signed University Hospitals Health System Compliance Program Certification;

22. payment of any application fees;

23. any other necessary documentation requested by the Credentials Committee, or its designees, to adequately evaluate the application;

24. copy of a government issued photo identification; and

25. For new applicants, authorization to perform a criminal background check.

F. PROCESSING APPLICATION

1. REQUEST FOR APPLICATION.

Upon receipt of the completed Request for Application, the Medical Staff Office shall send the appointment application.

2. ASSESSMENT.

Following submission of a completed application, the Medical Staff Office shall review the file for thoroughness and receipt of all required documentation. The Medical Staff Office has the right to request additional information or clarification of information presented by the applicant.

3. VERIFICATION OF INFORMATION.

The Medical Staff Office verifies the following from the primary source, when feasible:

a. professional education or ECFMG certification, residency, fellowship training and post-residency training;

b. current and former licensure, board specialty certifications;

c. previous professional experience;

d. the Medical Staff Office verifies the current clinical competence of an applicant by obtaining peer evaluations from hospitals or other health care entities where he/she has trained, held Medical Staff appointments, or clinical assignments; at least three (3) current clinical competence evaluations are required for initial appointment to the Medical Staff, but only one (1) such evaluation is required for reappointment.

4. QUERIES FOR INFORMATION.

The Medical Staff Office queries the following entities:

a. National Practitioner Data Bank (NPDB);

b. American Medical Association or American Osteopathic Association (if applicable), or any similar applicable organizations; and

c. State of Ohio licensure board(s) and the other state licensure boards, if applicable;

5. INCOMPLETE APPLICATION

The Medical Staff Office promptly informs the applicant of any missing information or problems in obtaining verification of information. The applicant is ultimately responsible for ensuring the receipt of this information. Action on an individual's application for initial appointment and clinical privileges shall be withheld until the above information is available and verified.

6. TIME PERIODS FOR PROCESSING

All individuals and groups required to act on a complete application for Medical Staff appointment and clinical privileges must do so in a timely and good faith manner.

7. STATUS REQUEST

Each applicant, and the clinical department of the Hospital to which the Medical Staff appointment and/or privileges are being processed, may be informed of the status of his/her application, upon request.

8. TERMINATION OF APPLICATIONS

Applications for Medical Staff appointment and clinical privileges that are incomplete shall remain active for 180 days. Applications shall be terminated upon written notice to applicant in the event that an application remains

incomplete at the end of a 180-day period. Applicants who desire to pursue a Medical Staff appointment and clinical privileges at a later date must contact the Medical Staff Office to reapply.

G. EFFECT OF APPLICATION

Every application for staff appointment shall be signed by the applicant, and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligation to provide continuous care and supervision of his patients, to abide by the Bylaws, Rules and Regulations, to accept committee assignments, to serve as an officer on his/her clinical service when requested, to accept consultation assignments where appropriate, and to participate in staffing the emergency service area and other special care units, insofar as the latter are related to the privileges which he has been granted. A statement shall also be included that the applicant has received, read, and understood the Bylaws, Rules and Regulations and that he/she agrees to be bound by the terms thereof if he/she is granted membership and clinical privileges, and to be bound by the terms thereof without regard to whether or not he is granted membership and/or clinical privileges, in all matters relating to consideration of his application.

H. VERIFICATION OF INFORMATION

The applicant shall deliver a completed application to the Medical Staff Office and payment of Medical Staff dues or fees, if any are required. The Hospital President shall be notified of the application. An outside agency may be used by the Hospital for collection of this information. The NPDB will be queried for any available information about the applicant. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information in a timely fashion. When collection and verification is accomplished, all such information shall be transmitted to the Credentials Committee and the appropriate department(s).

I. DEPARTMENT ACTION

After receipt of the application, the Chair or appropriate committee of each department to which the application is submitted, shall review the application and supporting documentation, and may conduct a personal interview with the applicant at their discretion. The Chair or appropriate committee shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges requested, and shall transmit to the Credentials Committee a written report and recommendation as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The Chair may also request that the Medical Executive Committee defer action on the application for a specified period of time based upon specific reasons as enumerated by the Chair.

J. CREDENTIALS COMMITTEE

1. The Credentials Committee shall review the application, evaluate and verify the supporting documentation, the department Chair's report and recommendations, and other relevant information. The Credentials Committee may elect to interview the applicant and seek additional information. The Credentials Committee shall transmit to the Medical Executive Committee its recommendations as to appointment and, if appointment is recommended, as to the membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment.

2. If the Credentials Committee determines that substantive matters are jeopardizing the applicant, the Credentialing Committee shall so notify the applicant and provide him with an opportunity to respond to the matter or such other action as is appropriate under the circumstances.

3. The Credentialing Committee may also recommend that the Medical Executive Committee defer action on the application for a specified period of time based upon specific reasons as enumerated by the Committee.

4. An applicant's complete application may be forwarded to the Medical Executive Committee without a Credentials committee review if the application is a clean application as defined by the absence of:

   a. An involuntary termination of Medical Staff membership at another institution;

   b. An involuntary limitation, reduction, denial, or loss of clinical privileges at any institution; or

   c. A final judgment adverse to the applicant in a professional liability action.

   d. Any current challenge or previously successful challenge to licensure or registration.

K. MEDICAL EXECUTIVE COMMITTEE ACTION

1. The Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Credentials Committee for further investigation, elect to interview the applicant or otherwise take action and make a recommendation to the Board following receipt of the report. The committee may also defer action on the application for a specified period of time. The reasons for each action and recommendation shall be stated.

2. Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, to the Board.

3. Adverse Recommendation: When the recommendation of the Medical Executive Committee is adverse to the applicant, the applicant shall be informed by written notice which notice shall include the basis for the adverse recommendation. Upon receipt of this notice the applicant shall be entitled to exercise his or her rights made by the hearing and appellate review procedures set forth in Section XI. The applicant's rights under Section XI must either be waived or exhausted before the Board may take action.

L. BOARD ACTION ON THE APPLICATION

The Board may accept the recommendation of the Medical Executive Committee or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral. The following procedures shall thereafter apply with respect to action on the application:

1. If the Board concurs with the recommendation of the Medical Executive Committee, the decision of the Board shall be deemed final action.

2. If the Board does not concur with the recommendation of the Medical Executive Committee, and the proposed decision of the Board is adverse to the applicant, the applicant shall be informed by written notice which notice shall include the basis for the proposed adverse decision. The applicant shall then be entitled to the fair hearing and appellate review procedures set forth in Section XI. If the proposed decision constitutes adverse action, as defined in the regulations implementing the NPDB, the notice shall include the actual wording of a 600 character (or less) description of the underlying action which will be reported to the NPDB in the Adverse Action report if the proposed action is adopted by the Board.

M. NOTICE OF FINAL DECISION

1. Notice of the final decision, if adverse, shall be either hand delivered or sent by certified mail, return receipt requested to the applicant and, in addition, given to the CMO, the Medical Executive Committee, the Credentials Committee, the Chair of each department concerned, and the Hospital President.

2. A decision and notice to appoint or reappoint shall include, if applicable:

   a. the staff category to which the applicant is appointed;

   b. the department to which he is assigned;

   c. the clinical privileges granted; and

   d. any special conditions attached to the appointment.

N. REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of one (1) year. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

O. REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

1. APPLICATION

a. At least forty-five (45) days prior to the expiration date of the current appointment period, each Medical Staff member shall submit to the Credentials Committee the completed application form for renewal of appointment to the staff for the coming year, and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section V, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth at Section VI.

b. A Member who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request at any time, except as such application may not be filed within 180 days of the time a similar request has been denied.

2. FAILURE TO FILE REAPPOINTMENT APPLICATION

Failure without good cause to timely file a completed application for reappointment shall result in the automatic expiration of the Member's admitting privileges and other practice privileges and prerogatives at the end of the current staff appointment. If the Member fails to submit a completed application for reappointment within thirty (30) days past the end of the current appointment, the member shall be deemed to have resigned membership in the Medical Staff. In the event membership terminates for the reasons set forth herein, the Fair Hearing and Appellate Review procedures set forth in Section XI shall not apply.

P. LEAVE OF ABSENCE

1. LEAVE STATUS

At the discretion of the Medical Executive Committee, a Member may obtain a voluntary leave of absence from the staff upon submitting a written request to the Medical Executive Committee stating the approximate period of leave desired, which may not exceed 365 days. The request must state the reasons for the leave such as military duty, additional training, family matters, or personal health condition. Absence from Medical Staff and patient care responsibilities for

longer than ninety (90) days shall require an individual to request a leave of absence. During the period of the leave, the Member shall not exercise clinical privileges at the Hospital, and the membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the Medical Executive Committee.

2. TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the Member's privileges and prerogatives, and the procedure provided in Sections IV through VI shall be followed.

3. FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement prior to terminating a leave of absence shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges and prerogatives. A Member whose membership is automatically terminated shall be entitled to the procedural rights provided in Section XI for the sole purpose of determining whether the failure to request reinstatement was unintentional, excusable or otherwise. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

Q. TEMPORARY MEDICAL STAFF MEMBERSHIP

When necessary for the conducting of peer review activities, the Medical Executive Committee may admit a physician or other individual to the Medical Staff for a limited period of time. Such membership shall be solely for the purpose of conducting peer review in a particular situation, and the temporary membership shall terminate upon the temporary member's completion of duties in connection with the peer review matter. The individual(s) need not go through the formal application procedure but need only be invited by the Medical Executive Committee to participate as an expert in peer review activities.

V. <u>CLINICAL PRIVILEGES</u>

A. CLINICAL PRIVILEGES

1. EXERCISE OF CLINICAL PRIVILEGES

Every licensed independent practitioner providing direct clinical services at the Hospital, by virtue of Medical Staff membership, professional services agreement, employment, or authorization to practice pursuant to the LIAP/AHP Policy, shall, in connection with such practice, be entitled to exercise only those setting-specific clinical privileges or provide patient care services as are specifically granted to him/her by the Board.

2. DELINEATION OF CLINICAL PRIVILEGES

a. If the Hospital lacks adequate facilities, equipment, number and types of qualified support personnel, or other resources for a specific service or procedure, clinical privileges are not granted in those areas.

b. Every application for Medical Staff appointment and reappointment must contain a request for the particular clinical privileges desired by the applicant. Clinical privileges are organization and setting-specific, and the evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated current competence, ability, peer references, and other relevant information, as appraised by the Credentialing Committee and Chair. Each applicant must meet the appropriate departmental training/experience and board certification requirements as outlined on the departmental privilege delineation form or in departmental policies for specialized procedures. However, special exceptions to these requirements may be requested at the discretion of the Chair. Exceptions shall be submitted in writing for approval to the CMO and the Hospital President who will forward approved requests to the Medical Staff Office for processing; this documentation shall become part of the credentialing file. The applicant shall have the responsibility of establishing his/her qualifications and competency in the area of clinical privileges requested.

c. There are mechanisms to ensure that Members provide services within the scope of privileges delineated.

3. INTERIM APPOINTMENT AND CLINICAL PRIVILEGES

a. After review and favorable recommendation by the Credentials Committee and upon recommendation of the Chairman and Chief Medical Officer, the President (or, in the absence of the President, when necessary, his/her designee) may grant an interim appointment and clinical privileges to a Medical Staff member meeting the following

criteria for a period not to exceed 120 days in order to complete the approval process. UH Credentialing Department (UHCD) will notify applicants of the approval of his/her interim appointment and clinical privileges no later than 10 days after Credentials Committee approval.

b. Eligibility Criteria for Interim Appointment to the Medical Staff

i. After review and favorable recommendation by the Credentials Committee and upon recommendation of the Chairman and Chief Medical Officer, the President (or, in the absence of the President, when necessary, his/her designee) may grant an interim appointment and clinical privileges to a Medical Staff member meeting approved criteria for a period not to exceed 120 days in order to complete the approval process.

ii. The following criteria shall be met prior to granting of an interim appointment.

A. Verification of:
1. Current licensure;
2. Current DEA registration (unless such registration is not required for the member's discipline, scope of practice; or requested privileges);
3. Relevant training or experience;
4. Current competence;
5. Ability to perform the privileges requested;
6. Other criteria required by the Medical Staff Bylaws.

B. Results of National Practitioner Data Bank (NPDB) have been obtained and evaluated.

C. Applicant has:
1. A complete application
2. No current or previously successful challenge to licensure or registration
3. Not be subject to involuntary termination of Medical Staff membership at another organization
4. Not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges

iii. If any interim appointment eligibility criterion is not met by the applicant, the applicant shall not be granted interim appointment and clinical privileges, and appointment and clinical privileges shall be granted only after approval by the full Board of Directors.

c. If any adverse information regarding the applicant's credentials, training, experience, clinical competence, ethics, or other pertinent facts become known to the Hospital during this time period, such information shall be reported simultaneously to the Chairman and the Chief Medical Officer. The Chairman shall make a recommendation regarding the appointee's continued interim appointment and clinical privileges to Medical Executive Committee and the Board of Directors. If necessary, the appointee's privileges may be summarily suspended in the manner outlined in Section X.A. of the Bylaws.

d. If there is a recommendation from Medical Executive Committee to terminate an interim appointee's appointment and/or clinical privileges, the appointee shall have due process as outlined in Section X. D.

4. Temporary Privileges

a. Eligibility Criteria for Temporary Privileges to the Medical Staff

i. After review and favorable recommendation by the Credentialing Committee and upon recommendation of the Department Chairman and Chief Medical Officer, the President (or, in the absence of the President, when necessary, his/her designee) may grant Temporary Privileges to a Medical Staff member meeting the following criteria for a period not to exceed 120 days in order to complete the approval process. The Hospital's Credentialing Department will notify applicants of the approval of his/her interim appointment and clinical privileges no later than 10 days after Credentialing Committee approval.

ii. The following criteria shall be met prior to granting of Temporary Privileges***:***

A) Verification of:

1) Current licensure;

2) Current DEA registration (unless such registration is not required for the member's discipline, scope of practice, or requested privileges);

3) Relevant training or experience;

4) Current competence;

5) Ability to perform the privileges requested;

6) Other criteria required by the Medical Staff Bylaws.

B) Results of National Practitioner Data Bank query have been obtained and evaluated.

C) Applicant has:

1) A complete application;

2) No current or previously successful challenge to licensure or registration;

3) Not been subject to involuntary termination of Medical Staff membership at another organization;

4) Not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

iii. If any Temporary Privilege eligibility criterion is not met by the applicant, the applicant shall not be granted Temporary Privileges, and appointment and clinical privileges shall be granted only after approval by the full Board of Directors.

If any adverse information regarding the applicant's credentials, training, experience, clinical competence, ethics, or other pertinent facts become known to the Hospital during this time period, such information shall be reported simultaneously to the Department Chairman and the Chief Medical Officer. The Department Chairman shall make a recommendation regarding the appointee's continued Temporary Privileges to Medical Executive Committee and the Board of Directors. If necessary, the appointee's privileges may be summarily suspended in the manner outlined in these Bylaws.

In the event a new applicant receives temporary privileges under this section within 90 days of the reappointment date for his/her clinical department, the Board shall take action on his/her initial application at the same time it takes action on the entire clinical department's applications for reappointment.

B. TELEMEDICINE PRIVILEGES

1. DEFINITIONS

a. *Telemedicine*. The use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment and services.

b. *Telemedicine Privileges*. Any Ohio-licensed independent practitioner who has either total or shared responsibility for patient care, treatment, and services is credentialed and privileged according to this Section VI.

c. *Originating Site*. Site where the patient is located at the time the service is provided.

d. *Distant Site*. The site where the practitioner providing the professional service is located.

e. *Services*. The Medical Staffs at both the originating and distant sites recommend in writing the clinical services to be provided by licensed independent practitioners through a telemedical link at their respective sites, consistent with commonly accepted quality standards and all applicable legal standards.

2. CREDENTIALING AND PRIVILEGING STANDARDS FOR TELEMEDICINE PRIVILEGES

a. Hospital as originating site:

i. Licensed independent practitioners who are responsible for the care, treatment and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site via one of the following mechanisms:

A) Hospital fully credential and privilege the practitioner according to Section VI of these Bylaws; or

B) Practitioner may be privileged for procedures performed via telemedicine link at the Hospital using credentialing information from the distant site if the distant site is JCAHO-accredited.

ii. Retains responsibility for overseeing safety and quality of services offered to its patients.

iii. The practitioner must either be licensed by the State Medical Board of Ohio or hold a Telemedicine Certificate from the State Medical Board of Ohio.

b. *Term of Privileges*. A practitioner may be granted telemedicine privileges for a maximum period of two (2) years, according to the staggered appointment schedule of the clinical department where telemedicine privileges are granted. Renewal of telemedicine privileges may be requested by the Chair, subject to the procedures in these Bylaws including Board Certification and Malpractice Requirements, or Practitioner may be privileged for procedures performed via telemedicine link at the Hospital using credentialing information from the distant site if the distant site is Joint Commission-accredited. Unless renewed, telemedicine privileges will automatically be terminated on the last day of the approved privileges period.

C. DISASTER PRIVILEGING PLAN

During a local, state, or national disaster in which the Hospital's emergency management plan has been activated, disaster privileges may be granted to volunteers eligible to be licensed independent practitioners who are not privileged by the Medical Staff when the Hospital is unable to handle the immediate patient needs.

1. POLICY AND PREREQUISITES

Any practitioner providing patient care must be granted privileges prior to providing patient care, even in an emergency/disaster situation. The practitioner granted disaster privileges (a modified credentialing and privileging process) is assigned to a department of the Medical Staff and paired with a Member of the Active Medical Staff in the same specialty. Disaster privileges are granted on a time-limited basis, for the duration dictated by the emergency management plan. Disaster privileges do not confer any status on the Medical Staff.

2. TYPES OF PRACTICES COVERED

Any physician, oral and maxillofacial surgeon, dentist, psychologist, podiatrist, physicians assistant or advanced practice registered nurse not privileged by the Medical Staff, or other licensed independent practitioners approved by the Hospital President and Chief Medical Officer, and presenting themselves as volunteers to render their services during an emergency or disaster shall be processed accordingly.

3. WHO MAY GRANT DISASTER PRIVILEGES ("PRIVILEGING AUTHORITY")

The Hospital President, or CMO, or their designee, has Privileging Authority to grant Disaster Privileges.

4. RESPONSIBILITIES OF PRIVILEGING AUTHORITY

a. The Privileging Authority is not required to grant privileges to any individual;

b. Granting of disaster privileges is on a case-by-case basis when an emergent patient care need mandates an immediate authorization to practice;

c. The Privileging Authority will grant authorization based on, at a minimum, receipt of a key identification document (see below), completion of the Disaster Privileges Request Form and the applicant's acknowledgement of *Disaster Privileging: Practitioner Responsibilities.*

d. The Privileging Authority will assign or appoint a designee to assign the volunteer practitioner to a department and assign a Member of the same discipline to pair with/supervise the volunteer practitioner for the duration of the disaster privileges.

e. The Privileging Authority will document initial authorization to practice.

f. The Privileging Authority will review verified credentials once the immediate situation is under control.

g. The Privileging Authority will include responsibilities of the privileging authority and the mechanism for managing individuals who receive disaster privileges in the Hospital's emergency management plan.

5. MECHANISM FOR MANAGING INDIVIDUALS WHO RECEIVE DISASTER PRIVILEGES

The practitioner shall first be routed to the Medical Staff Office (or specific) area for:

a. Identification;

b. Pairing;

c. Authorization;

d. Verification; and

e. Documentation.

6. DISASTER PRIVILEGING PROCESS IDENTIFICATION.

Personal Identification and Authorization to Practice, evidenced by a valid government-issued photo identification issued by a state or federal agency (e.g. driver's license or passport) and at least one of the following:

i. Current Hospital/entity identification card that clearly identifies the professional designation;

ii. Proof of current license to practice (e.g., documentation from Ohio licensure board);

iii. Primary source verification of the license;

iv. Identification indicating that individual is a member of a Disaster Medical Assistant Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups;

v. Identification indicating that individual has been granted authority to render patient care in disaster circumstances, such authority having been granted by a federal, state, or municipal entity; or

vi. Identified by a current member of the Hospital or Medical Staff member who possesses personal knowledge regarding practitioner's ability to act as a licensed independent practitioner during a disaster.

After completion of the personal identification process detailed above, the practitioner shall be given the standardized regional Disaster Privileges badge by Medical Staff Office to ensure ready identification of the volunteer. The badge shall include name, degree/title, ID number, start date of disaster privileges, any limitations, name of Medical Staff member paired with volunteer, name of issuing Medical Staff Office staff, and authorization to practice by the Privileging Authority if clinical practice

approved for immediate situation, prior to completion of credentials verification.

7. DISASTER PRIVILEGING PROCESS; PAIRING

The Medical Staff shall oversee the professional practice (care, treatment, and services provided) of volunteer licensed independent practitioners through direct observation, mentoring, and clinical record review. The privileging authority or designee shall assign the volunteer practitioner to a department and assign a member of the active Medical Staff in the same specialty to pair with/supervise the volunteer practitioner for the duration of the disaster privileges.

8. DISASTER PRIVILEGING PROCESS: VERIFICATION OF CREDENTIALS AND PRIVILEGES

a. A disaster privileges credentials file shall be maintained by Medical Staff Office for each practitioner granted disaster privileges;

b. Practitioner shall fully complete a Disaster Privileges Request Form, including attestation;

c. Practitioner shall present proof of Ohio licensure, DEA and current certificate of liability insurance, where feasible.

d. Medical Staff Office shall primary source verify the following Ohio professional licensure/certification/registration as soon as the immediate situation is under control, within 72 hours from the time the volunteer presents to the Hospital. If extraordinary circumstances prevent primary source verification within 72 hours (e.g. no means of communication or lack of resources), verification will be done as soon as possible. Medical Staff Office shall document (a) why the verification could not be performed in the required time frame; (b) evidence of a demonstrated ability to continue to provide adequate care, treatment, or services; and (c) an attempt to rectify the situation as soon as possible.

e. Medical Staff Office shall verify/query the following when possible:

i. Ohio professional licensure;

ii. Current certificate of professional liability insurance;

iii. DEA certification;

iv. Board certification or education and training if not board certified;

v. Privileges and status at primary hospital/entity; and

vi. NPDB.

f. The Privileging Authority or designee will review and sign off on the credentials file of each practitioner granted disaster privileges.

g. Medical Staff Office shall notify appropriate Hospital departments, when feasible.

h. If any negative information is obtained during the credentials verification process, the Privileging Authority may require the practitioner to immediately cease and desist clinical services, relinquish the standardized regional Disaster Privileges badge, and submit documentation of all clinical activities performed on the patient treatment documentation form.

i. The denial, termination, reduction or restriction of disaster privileges shall not give rise to any rights contained in the entity's Bylaws, rules, or policies and procedures of the entity and Medical Staff, including but not limited to a hearing or appellate review.

9. DISASTER PRIVILEGING PROCESS: DOCUMENTATION

a. When feasible, a Disaster privileges credentials file will be created by and maintained in Medical Staff Credentialing for each practitioner. It should contain the following:

i. Completed Disaster Privileges Request Form with credentials checklist;

ii. Signed Disaster Privileging: Practitioner Responsibilities;

iii. Copy of personal identification listed above;

iv. Verification of Ohio licensure or exemption per Ohio Revised Code §4731.36;

v. Verification of board certification or education and training;

vi. Verification of status at primary hospital/entity;

vii. Verification of professional liability insurance coverage;

viii. Verification of DEA certification;

ix. NPDB Query;

x. Approval of Privileging Authority; and

xi. Patient Treatment Documentation Form.

10. DURATION OF DISASTER PRIVILEGES

Disaster privileges are valid only for the duration of the declared emergency and terminate automatically when the emergency is over.

11. LIST OF PATIENTS TREATED

A list of patients treated by the practitioner granted disaster privileges shall be documented by Hospital on the *Disaster Privileges Patient Documentation Form* and maintained in the practitioner's credentials file.

D. MEDICAL EMERGENCY PRIVILEGES FOR EXISTING MEMBERS

In the case of an emergency, any individual Member with clinical privileges is "temporarily privileged" to provide any type of patient care necessary as a life-saving measure or to prevent serious harm – regardless of his or her current clinical privileges – if the care provided is within the scope of his/her license.

E. BYLAWS EXCEPTIONS

Any qualifications, requirements or limitations in this Section or any other Section of these Bylaws not required by law or governmental regulation, may be waived at the discretion of the Hospital President (or, in the absence of the Hospital President, when necessary, his/her designee), upon determination that such waiver will serve the best interests of the patients and of the Hospital, and provided that the Chief Medical Officer has given prior approval of such request. All such requests shall be submitted in writing to the Chief Medical Officer.

VI. OFFICERS

A. IDENTIFICATION

The officers of the Medical Staff shall be the President, President-Elect, Secretary, and Treasurer.

B. QUALIFICATIONS

Officers must be members of the active Medical Staff with voting rights at the time of their nomination and election, and must remain Members in good standing during their term of office. The President and President Elect must be Board Certified in their respective specialty at the time of nomination and throughout

their term. The President-Elect must also, at the time of his/her nomination, have served at least one year as a current or previous (a) member of the Medical Executive Committee, (b) Department chair, or (c) chair of a committee. "Good Standing" shall be determined by predetermined criteria which shall be accepted and approved by the Medical Executive Committee. Failure to maintain such status shall immediately create a vacancy in the office involved. Officers shall not be Department Chairs.

C. NOMINATIONS

1. The officers shall be nominated and elected at the annual Medical Staff meeting as prescribed in Section X.

    a. The Chief Medical Officer, with the concurrence of the Medical Executive Committee, shall appoint a nominating committee three months prior to the election. The nominating committee shall consist of the immediate past president of the Medical Staff, who shall serve as chair; one member of the Medical Executive Committee; and three members of the active Medical Staff. No member of the nominating committee is eligible for nomination.

    b. The function of the five member nominating committee shall be to meet annually and present a slate of officers to the Medical Staff at least two weeks prior to the annual meeting.

2. The nominating committee shall nominate one or more nominees for each office which will become vacant. The nominations of the committee shall be reported to the Medical Staff as previously mentioned. Further nominations may be made by any member of the Medical Staff provided that the name of the candidate is submitted in writing to the chair of the nominating committee, is endorsed by the signatures of at least ten percent (10%) of other members who are eligible to vote, and bears the candidate's written consent. The nomination must be submitted in writing to the Medical Staff one week prior to the annual Medical Staff meeting. The nominations shall be submitted on a form approved by the Medical Executive Committee. Nominations from the floor shall not be in order.

D. ELECTIONS

The President Elect, Secretary, and Treasurer shall be elected at the annual meeting of the Medical Staff that falls during the election year. Voting may be by electronic vote. The members of the Medical Staff eligible to vote must receive ten (10) days' electronic notice of any election. The notice must include an electronic ballot through which each eligible member may vote by an affirmative vote of the majority of eligible votes cast within the ten (10) day notice period. If electronic voting cannot or is not used, voting shall be by secret, written ballot. Authenticated sealed absentee ballots may be counted. Members shall submit

their absentee ballot in an unlabeled envelope, which is placed in another envelope that contains Member's signature, which validates the vote. Written ballots shall include handwritten signatures on file, when necessary. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election by secret written ballot at its next meeting called for that purpose. With the approval of the Medical Executive Committee and subject to such procedures as the Medical Executive Committee may reasonably impose, the election of Medical Staff officers may be conducted by a mail ballot or via electronic means.

E. TERM OF ELECTED OFFICE

Each officer shall serve one (1) two (2) year term, commencing on the first day of the Medical Staff year following his or her election. Each officer shall serve in office until the end of his or her term, unless he or she resigns or is removed from office. At the end of his or her term, the President-Elect shall automatically assume the office of President.

F. RECALL OF OFFICERS

1. Except as otherwise provided, recall of a Medical Staff officer may be initiated by majority vote of the Medical Executive Committee or shall be initiated by a petition signed by at least one-third (1/3) of the Members eligible to vote for Medical Staff officers at a regularly scheduled meeting or at a special meeting called for that purpose. Recall shall require a two-thirds vote of the Medical Staff members eligible to vote for Medical Staff officers at the meeting at which recall is considered.

2. A Medical Staff officer may be removed by the Board in accordance with processes defined in these Bylaws:

   a. For conduct detrimental to the interests of the hospital; or

   b. If the officer is suffering from a physical or mental infirmity (as determined by Medical Staff Wellness Committee Process) that renders the individual incapable of fulfilling the duties of that office.

3. Notice of the meeting at which action shall be decided shall be given in writing to the officer at least ten (10) days prior to the meeting. The officer shall be afforded the opportunity to speak prior to the taking of any vote on such removal.

4. An officer who is found by the Board to no longer meet one or more of the qualifications for officers set forth in these Bylaws shall automatically relinquish his/her office.

G. VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of Medical Staff membership in the Medical Staff. Vacancies, other than that of President, shall be filled by appointment by the Medical Executive Committee until the next regular election. If there is a vacancy in the office of President, the President-Elect shall serve on that remaining term and shall immediately appoint an ad hoc nominating committee to decide promptly upon nominees for the office of President-Elect. Such nominees shall be reported to the Medical Executive Committee and to the Medical Staff. A special election to fill the position shall occur at the next regular staff meeting. If there is a vacancy in the office of President-Elect, that office need not be filled by election, but the Medical Executive Committee shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of president.

H. DUTIES OF OFFICERS

1. PRESIDENT

The President shall serve as the Chief of Staff of the Medical Staff. The duties of the President shall include, but not be limited to:

i. Enforcing the Bylaws and Rules and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated.

ii. Calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff.

iii. Serving as Chair of the Medical Executive Committee, with vote.

iv. Serving as an ex-officio member of all other staff committees. As an ex-officio member of such committees, the chief of staff will have no vote, unless his or her membership in a particular committee otherwise is required by these Bylaws.

v. Interacting with the Hospital President, CMO and the Board in all matters of mutual concern within the hospital. The President shall be a voting member of the Board.

vi. 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.

vii. Representing the views and policies of the Medical Staff to the Board and to the Hospital President.

viii. Being a spokesperson for the Medical Staff in external professional and public relations.

ix. Performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff, or by the Medical Executive Committee.

x. Serving on liaison committees with Board and administration, as well as outside licensing or accreditation agencies.

2. PRESIDENT ELECT

The President-Elect shall assume all duties and authority of the President in the absence of the President. The President-Elect shall be a member of the Medical Executive Committee of the Medical Staff, shall chair the Performance Improvement Council, and shall perform such other duties as the President may assign or as may be delegated by these Bylaws, or by the Medical Executive Committee. In the discretion of the current President of the Medical Staff, the President-Elect shall complete a course of continuing medical education relating to Medical Staff issues or governance prior to taking office as President.

3. SECRETARY

The Secretary shall be a member of the Medical Executive Committee. The duties shall include, but not be limited to:

i. Maintaining a roster of Members;

ii. Supervises the keeping accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings;

iii. Calling meetings on the order of the President or Medical Executive Committee;

iv. Attending to all appropriate correspondence and notices on behalf of the Medical Staff;

v. Excusing absences from meetings on behalf of the Medical Executive Committee;

vi. Performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief Medical Officer or Medical Executive Committee.

4. TREASURER

The Treasurer shall be a member of the Medical Executive Committee. The duties shall include, but not be limited to:

i. receiving and safeguarding all funds of the Medical Staff;

ii. rendering an annual report for presentation at the last Medical Staff meeting of each year; and

iii. performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

5. HOSPITAL MEDICAL STAFF REPRESENTATIVE AND ALTERNATE

The positions of Hospital Medical Staff Section representative and alternate to the local, state and national Hospital Medical Staff section shall be elected by the Medical Staff.

6. BOARD OF DIRECTORS/TRUSTEES REPRESENTATIVES

Medical Staff may serve as representatives on the Hospital's Board as set forth in the Hospital's Code of Regulations, which may be amended from time to time.

VII. CLINICAL DEPARTMENTS AND DIVISIONS

A. ORGANIZATION OF CLINICAL DEPARTMENTS AND DIVISIONS

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a Chair selected and entrusted with the authority, duties, and responsibilities specified in these Bylaws. A department may be further divided, as appropriate, into divisions which shall be directly responsible to the department within which it functions, and which shall have a division chief selected and entrusted with the authority, duties and responsibilities specified in these Bylaws. When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of departments or divisions.

B. CURRENT DEPARTMENTS AND DIVISIONS - The current departments are: Medicine, Surgery, Obstetrics and Gynecology, Family Practice, Pediatrics, Radiology, Pathology, Anesthesiology, and Emergency Medicine. The Divisions of each Department shall be determined by the members of that Department.

C. ASSIGNMENTS TO DEPARTMENTS AND DIVISIONS

Each Member shall be assigned membership in at least one department, and to a division, if any, within such department, but may also be granted membership and/or clinical privileges in other departments or divisions consistent with practice privileges granted.

D. FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

a. Conducting patient care review for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department, and for promoting system-wide best practices throughout UH-owned facilities. The number of such reviews to be conducted during the year shall be as determined by the Medical Executive Committee in consultation with other appropriate committees. The department shall routinely collect information about important aspects of patient care provided in the department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the

member whose work is subject to such review is a member of that department.

b. Recommending to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the department.

c. Evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department.

d. Conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice.

e. Designing, monitoring, assessing, and improving the effectiveness, efficacy, availability, timeliness, appropriateness, accessibility, continuity, efficiency, and safety of patient care and respect for patients through active involvement in the Hospital's Performance Improvement Plan.

f. Reviewing and evaluating departmental adherence to: (1) Medical Staff policies and procedures; and (2) sound principles of clinical practice.

g. Coordinating patient care provided by the department's members with nursing and ancillary patient care services.

h. Submitting written reports to the Medical Executive Committee and performance improvement committees concerning:

   i. the department's review and evaluation activities, actions taken thereon, and the results of such action; and

   ii. recommendations for maintaining and improving the quality of care provided in the department and the hospital.

i. Meeting at least quarterly for the purpose of considering monthly patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions.

j. Establishing and appointing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols.

k. Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.

l. Accounting to the Medical Executive Committee for all professional Medical Staff administrative activities within the department.

m. Formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee.

E. FUNCTIONS OF DIVISIONS

Subject to approval of the Medical Executive Committee, each Division shall perform the functions assigned to it by the Department Chair. Such functions may include, without limitation, retrospective patient care reviews, evaluation of patient care practices, credentials review and privilege delineation, and continuing education programs. The Division shall transmit regular reports to the department Chair on the conduct of its assigned functions.

F. DEPARTMENT CHAIRS

1. QUALIFICATIONS

Each department shall have a Chair who shall be a Voting Member of the Active Medical Staff. He/she shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the department and must be board certified in his/her specialty. Each department may have a Vice-Chair with the same qualifications as the Chair.

Department Chairs shall be elected by those members of the department who are eligible to vote for general officers of the Medical Staff with the exception of hospital-based departments.

Election of Department Chair will be by mail ballot. Three (3) months prior to the election, the Medical Staff Office will mail to the Active Medical Staff a list of Appointees from their Department who meet the qualifications to serve as Department Chair. The Department members may nominate anyone from the list. The Medical Staff Office shall contact all nominated Department members to determine if they are willing to serve. Ballots will be mailed to the active Appointees to register their votes for Department Chair. The nominee must receive a majority of the votes cast to become Department Chair. If a majority vote is not received, a secondary runoff mail ballot will take place between the two

(2) nominees receiving the highest number of votes. Department Chairs shall be elected in alternate years from the Medical Staff officers.

Vacancies due to any reasons shall be filled for the unexpired term through a special election by the respective department with such mechanisms as that department may adopt.

2. TERM OF OFFICE

Each Department Chair shall serve a two (2) year term which coincides with the Medical Staff year or until their successors are chosen, unless the Chair resigns, is removed from office, or he/she loses his/her Medical Staff membership or clinical privileges in that department. Department Chairs shall be eligible to serve no more than two consecutive terms.

3. REMOVAL

After election and ratification, removal of Department Chairs or Vice-Chairs from office may occur for cause by two-thirds (2/3) vote of both the Medical Executive Committee and of the department members eligible to vote on departmental matters, and approved by the Board.

A Medical Staff Department Chair may be removed by the Board in accordance with processes defined in these Medical Staff Bylaws:

a. for conduct detrimental to the interests of the Hospital; or

b. if the Department Chair is suffering from a physical or mental infirmity (as determined by the Physician Wellness Committee Process) that renders the individual incapable of fulfilling the duties of that office.

Notice of the meeting at which action shall be decided shall be given in writing to the Department Chair at least ten (10) days prior to the meeting. The Department Chair shall be afforded the opportunity to speak prior to the taking of any vote on such removal.

A Department Chair who is found by the Board to no longer meet one or more of the qualifications for department chairs set forth in these Bylaws shall automatically relinquish his/her office.

4. DEPARTMENT CHAIR RESPONSIBILITIES

The Department Chair shall organize the department as appropriate to achieve the purposes of the Medical Staff. This includes the appointment of Division Chiefs of clinical subspecialties, where appropriate. The Department Chair shall be responsible, either personally or through delegation, for the following:

a. all clinically-related activities of the department;

b. all administratively related activities of the department, unless otherwise provided for by the Hospital;

c. the integration of the department into the primary functions of the Hospital organization;

d. the coordination and integration of interdepartmental and intradepartmental services;

e. the development and implementation of policies and procedure that guide and support the provision of services;

f. recommendations for a sufficient number of qualified and competent persons to provide care/services;

g. continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the department;

h. recommending to the Medical Executive Committee the criteria for clinical privileges in the department;

i. recommending clinical privileges for each member of the department;

j. assessing and recommending to the relevant hospital authority off-site sources needed for needed patient care services not provided by the department or the hospital.

k. the continuous assessment and improvement of the quality and safety of care and services provided.

l. Monitoring compliance by all persons within the department with Bylaws, Rules and Regulations, University Hospitals Health System Compliance Guidelines, departmental rules, and other Hospital policies.

5. DEPARTMENT VICE CHAIR ELECTION AND RESPONSIBILITIES

Each Vice Chair shall be appointed by the Department Chair election of chair, subject to the approval of the MEC and the Board. The Vice Chair shall exercise all of the responsibilities of the Chair, in the absence of the Chair.

G. DIVISION CHIEFS

1. QUALIFICATIONS

Each Division shall have a Chief who shall be a Member of the Active Medical Staff and a member of the division which he or she is to head, and shall be qualified by training, experience and demonstrated current ability in the clinical area covered by the Division, and shall be certified by an appropriate specialty board, or shall possess comparable competence, as determined by the Credentialing Committee and approved by the Medical Executive Committee and Board. Whenever possible, the Chief shall be a voting member of the Active Staff. Division chiefs shall be appointed by their respective Department Chairs, with the approval of the Medical Executive Committee and the Board.

2. TERM OF OFFICE

Each Division Chief shall serve a two (2) year term which coincides with the Medical Staff year or until his or her successor is chosen, unless he or she resigns or is removed from office or loses Medical Staff membership or clinical privileges in that division. Division Chiefs shall be eligible to serve consecutive terms.

3. REMOVAL

A division chief may be removed by the department Chair with the approval of the Medical Executive Committee and the Board.

A Division Chief may be removed:

a. for conduct detrimental to the interests of the hospital; or

b. if the Division Chief is suffering from a physical or mental infirmity (as determined by the Physician Wellness Committee Process) that renders the individual incapable of fulfilling the duties of that office.

c. Notice of the meeting at which action shall be decided shall be given in writing to the Division Chief at least ten (10) days prior to the meeting. The Division Chief shall be afforded the opportunity to speak prior to the taking of any vote on such removal.

d. A Division Chief who is found by the Board to no longer meet one or more of the qualifications for officers set forth in these Bylaws shall automatically relinquish his/her office

4. DUTIES - Each Division Chief shall:

a. Act as presiding officer at Division meetings.

b. Assist in the development and implementation, in cooperation with the Department Chair, of programs to carry out the performance

improvement review, evaluation and monitoring functions assigned to the division; and in the promotion of system-wide best practices throughout UH-owned facilities.

c. Evaluate the clinical work performed in the division.

d. Conduct investigations and submit reports and recommendations to the department Chair regarding the clinical privileges to the exercised within his division by members of or applicants to the Medical Staff.

e. Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Department Chair, the President, or the Medical Executive Committee.

VIII. ELECTED AND APPOINTED POSITIONS ON THE MEDICAL STAFF

Any position created under these Bylaws for which the appointment/election responsibility resides in the Medical Staff shall be compensated, if at all, solely at the discretion and expense of the Medical Staff or the Hospital. Hospital shall have no obligation to pay for or reimburse any Member for the performance of the duties and functions of such positions.

IX. MEETINGS

A. ANNUAL MEETING

There shall be an annual meeting of the Medical Staff. The President of the Medical Staff, or such other officers, department Chairs, division Chiefs, committee Chairs or Medical Executive Committee may designate, shall present reports on actions taken during the preceding year and on other matters of interest and importance to the Members. Notice of this meeting shall be given to the Members at least fourteen (14) days prior to the meeting.

B. REGULAR MEETINGS

Regular meetings of the Members shall be held, except that the annual meeting shall constitute the regular meeting during the month in which it occurs. The date, place and time of the regular meetings shall be determined by the Medical Executive Committee, and adequate notice shall be given to the members.

C. AGENDA

The order of business at a meeting of the Medical Staff shall be determined by the president of the Medical Staff and Medical Executive Committee. The agenda shall include, insofar as feasible:

1. Reading and acceptance of the minutes of the last regular meeting and all special meetings held since the last regular meeting;

2. Administrative reports from the President of the Medical Staff, departments, and committees, and the Hospital President;

3. Election of officers when required by these Bylaws;

4. Reports by responsible officers, committees and departments on the overall results of performance improvement, evaluation, and monitoring activities of the staff and on the fulfillment of other required staff functions;

5. Old business; and

6. New business

D. SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the president of the Medical Staff or the Medical Executive Committee, or shall be called upon the written request of ten percent (10%) of the voting Members of the Active Medical Staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the President of the Medical Staff or the Medical Executive Committee within thirty (30) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the Members which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

E. COMMITTEE AND DEPARTMENT MEETINGS

1. REGULAR MEETINGS:

Except as otherwise specified in these Bylaws, the Chair of committees, departments and divisions may establish the times for the holding of regular meetings. The Chair shall make every reasonable effort to ensure that the meeting dates are disseminated to the Members with adequate notice.

2. SPECIAL MEETINGS:

A special meeting of any Medical Staff committee, department or division may be called by the Chair thereof, the Medical Executive Committee, or the president of the Medical Staff, and shall be called by written request of one-third (1/3) of the current Members, eligible to vote.

F. QUORUM

Medical Executive Committee & Credentials Committee: The presence of at least fifty percent (50%) of the physician members shall constitute a quorum.
Staff meetings and committee meetings, with the exception of the Medical Executive Committee and the Credentials Committee, members present shall constitute a quorum with a minimum of two (2) members present. However, if the election of Medical Staff officers or the approval of Bylaws changes is to be conducted at a general Medical Staff meeting, then the quorum required for these actions is forty percent (40%) of the Active Voting Medical Staff of the Hospital.

G. MANNER OF ACTION

Except as otherwise specified, the action of a majority of the Members present and voting at a meeting at which a quorum is present or, if electronic, voting without quorum or attendance requirements, shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business not withstanding the withdrawal of members. Any action taken must be approved by at least a majority of the required quorum for such meetings, or such greater number as may be specifically required by these Bylaws. Committee action may be conducted by telephone conference which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken without a committee meeting if it is acknowledged in writing which sets forth the action so taken. At the time of committee appointments, the President of Medical Staff shall designate voting and non-voting members of the committee, which may include physicians other than Active Medical Staff Members and administrative personnel. The committee chair or the president of the Medical Staff may designate another chair to conduct the meeting in the absence of the regular chair.

H. MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. A copy of the minutes shall be approved by the presiding officer of the meeting and forwarded to the Medical Executive Committee.

I. ATTENDANCE REQUIREMENTS

1. REGULAR ATTENDANCE:

Except as stated below, each Member of the Active Medical Staff during the term of appointment who are entitled to attend meetings under Article IV shall be required to attend, unless excused by the President of the Medical Staff or the Chief Medical Officer:

a. At least fifty percent (50%) of all other general staff meetings duly convened pursuant to these Bylaws, including the annual Medical Staff meeting.

b. At least fifty percent (50%) of all meetings of each department, division, and committee of which he or she is a member.

c. Members of the Active Non-Voting and Courtesy Staffs are encouraged to attend meetings, and may be required to attend such other meetings as may be determined by the Medical Executive Committee.

2. ABSENCE FROM MEETINGS:

Any Member who is compelled to be absent from any Medical Staff, department, division, or committee meeting shall promptly provide to the regular presiding officer thereof the reason for such absence. Unless excused for good cause by the presiding officer of the department, division or committee, or the secretary-treasurer for Medical Staff meetings, failure to meet the attendance requirements may be grounds for removal from such committee.

3. SPECIAL ATTENDANCE:

At the discretion of the Chair or presiding officer, when a Member's practice or conduct is scheduled for discussion at a regular department, division, or committee meeting, the Member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting either by hand delivery or by certified mail, return receipt requested, and shall include the time and place of the meeting and a general indication of the issues involved. Failure of a Member to appear at any meeting, with respect to which he was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for corrective action.

J. CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

X. DISCIPLINE AND DISMISSAL FROM THE MEDICAL STAFF

A. AUTOMATIC SUSPENSION OR REVOCATION

1. Loss of license to practice in Ohio shall result in immediate termination of a Staff Member's appointment to and clinical privileges on the Medical Staff; involuntary loss of a permit to prescribe narcotics will result in immediate

termination of a Member's appointment to and clinical privileges on the Medical Staff.

2. A Member's conviction of or pleading guilty to a felony in any court in the United States, either federal or state, shall result in the immediate termination of a Member's appointment to and clinical privileges on the Medical Staff.

3. Suspension, voluntary relinquishment of, or agreement with a governmental entity not to exercise a license or permit to prescribe narcotics, or notice of exclusion/debarment from participation in the Medicare, Medicaid or other federal or state health care program shall be cause for automatic suspension of Member's appointment to and clinical privileges on the Medical Staff. This Section shall not apply to the lapse of a narcotics license or permit under circumstances where the member is not required to hold a license or permit to exercise clinical privileges and the member was not under investigation for violation of the law. The lapse or any loss or suspension of such license or permit shall be reported to the appropriate Chair and the CMO.

4. Whenever a Member's licensure or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the Member has been granted at the hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner as of the date such action becomes effective and throughout its term.

5. In the event that the privileges of a Member are automatically suspended, restricted or revoked, alternate medical coverage shall be provided for the Member's patients who remain in the Hospital. Whenever practicable, the desires of the patient will be considered in the choice of substitute Member and all such substitutions shall be made in the best interests of patient care. The CMO or Department Director shall be responsible for ensuring that such coverage is provided.

6. In the following instances, the Member's privileges and membership may be suspended or limited, which action shall be final without a right to hearing or further review. Suspension will be for the time in which it takes the member to demonstrate evidence of his or her compliance with the stated requirements below, not to exceed thirty (30) days. Noncompliance at the end of thirty (30) days will be construed as a voluntary resignation on the Member's behalf.

   a. Licensure: Failure to renew/supply evidence of medical license to practice within the State of Ohio prior to expiration date.

   b. DEA Registration: Failure to renew/supply evidence of Federal DEA Registration prior to the expiration date (unless such

registration is not required for the Member's discipline, scope of practice, or requested privileges).

c. Professional Liability Insurance: Failure to supply evidence of renewed professional liability insurance in the amount determined by the Medical Executive Committee and the Board prior to the expiration date.

d. Communicable Disease Policy: Failure to comply with the Hospital's communicable disease policy by failing to be tested for tuberculosis, hepatitis B, or other diseases identified by such policy from time to time, or by failing to submit the results of such screenings.

e. Mandatory Professional Education: Failure to provide satisfactory evidence of completing Hospital mandatory professional education programs, as defined by the Chief Medical Officer and the President.

f. UH and Compliance Programs: Failure to comply with the training and reporting requirements of any Hospital or UH Compliance Program or Policy in accordance with the stated program or policy.

g. Medical Records: Failure to complete medical records in a manner that is timely and consistent with the policies set forth by UH, the Hospital, the President, the Chief Medical Officer, and/or the Medical Executive Committee.

7. Provisions of these Bylaws relating to appeals, hearings, and appellate review shall not apply to the loss of Medical Staff appointment and clinical privileges resulting from an Automatic Suspension under this Section of these Bylaws, or due to the Member's failure to complete medical records, or any suspension of clinical privileges that is less than two weeks in duration.

8. All deadlines established in Section XI of the Bylaws shall be subject to amendment or change by mutual agreement of the affected physician and the Hospital.

B. CORRECTIVE ACTION

1. Staff appointments may be suspended, permanently revoked or limited for due cause, including but not limited to physical or mental disability, impairment (regardless of cause), failure to provide adequate patient care, or failure to abide by these Bylaws, or the Rules and Regulations and policies of the Medical Staff or Hospital, including approved and published policies of Departments, Sections, and Committees.

2. Any individual may provide information pertaining to a Member's conduct, performance or competence. Such information may be provided to any member of the Medical Executive Committee, the CMO, any Department Chair or the Hospital President. But all proposals to revoke or limit the Medical Staff privileges or appointment of a Member for due cause shall be submitted to the CMO for further action.

3. Upon receipt of a proposal to limit or revoke the Medical Staff privileges of a Member, the CMO may commence his or her own initial investigation of the facts surrounding the proposal, including contacting the affected Member. If the CMO does not believe that the facts and circumstances warrant further inquiry or disciplinary action, the CMO may either pursue a resolution with the affected Member outside of the formal Corrective Action process established by these Bylaws, or terminate the inquiry.

4. If the information provided to or discovered by the CMO would indicate to a reasonable person that further, formal inquiry is warranted, the CMO shall refer the matter to the Medical Executive Committee for its review and further action. During this process, the affected Member shall remain a Member of the Medical Staff, and his or her privileges and appointment shall continue until a final decision is reached by the Board.

a. Within a reasonable time following the referral by the CMO, the Medical Executive Committee, or its designee, shall conduct its own investigation of the applicable facts. This investigation shall be conducted in a reasonable, good faith manner, and shall include written notice of the investigation to the affected Member.

b. The affected Member shall be entitled to submit a written statement of his or her position regarding the investigation to the Medical Executive Committee.

c. Upon completion of its investigation, the Medical Executive Committee shall make a written recommendation to the Board including the facts and premises underlying the recommendation, and shall provide a copy of its recommendation to the affected Member. If the recommendation of the Medical Executive Committee is adverse to the Member, then this notice shall constitute notice of the Member's right to request a Fair Hearing under these Bylaws. The Medical Executive Committee's recommendation may include, without limitation:

i. Rejecting the request for corrective action;

ii. Issuing a warning, a letter of admonition, or a letter of reprimand;

iii. Recommending terms of probation or requirements of consultation, without restriction on privileges;

iv. Recommending reduction, restriction, suspension or revocation of clinical privileges; and

v. Recommending suspension or revocation of Medical Staff appointment.

d. If the Medical Executive Committee's recommendation is to suspend, revoke or limit the Member's staff appointment or privileges, then the Member shall be entitled to exercise his or her rights to a fair hearing under Section XI of these Bylaws.

e. Upon receipt of the recommendation of the Medical Executive Committee, and where the Member does not request a Fair Hearing, the Board may accept, reject or modify the recommendation of the Medical Executive Committee. The Board's decision shall be final.

5. In the event formal corrective action is taken against a practitioner holding privileges at other UH wholly-owned facilities, the Chief Medical Officer and the President of each such facility, the President, Chief Medical Officer, Medical Executive Committee, and Credentialing Committee of each such facility, the division chief to which the practitioner reports at such facility, and the UH Chief Medical Officer shall be notified that such corrective action has been taken at the Hospital; provided that such dissemination be conducted in accordance with the provisions of Section XII below. Where applicable, the President of any UH-owned entity that employs the practitioner shall be notified in the same manner. For purposes of this section only, "formal corrective action" means corrective action as described in section 4(c)(ii) through (v) above, summary suspension, and automatic suspension unrelated to completion of medical records. In instances where a practitioner is entitled to the Fair Hearing rights set forth below, such dissemination shall not occur until the practitioner has either waived or fully exhausted such rights, except in cases of summary suspension.

6. Nothing in this Section shall preclude Medical Staff leadership from engaging in efforts to address performance, behavioral or competency issues prior to resorting to formal corrective action described in sections 4(c)(ii) through (v) above. Such collegial interventions shall not be deemed to be corrective actions and shall not give rise to Hearing or Appellate rights and shall not subject the practitioner to reporting to the Ohio State Medical Board or the NPDB, except as otherwise provided in these Bylaws. By way of example, alternatives to corrective action may include, without limitation:

a. Informal discussions or meetings concerning the performance, behavior or competency that gave rise to the complaint,

b. Written letters of guidance

c. Notification of the potential for future monitoring and of expectations for improvement or compliance,

d. Suggestions for methods to improve behaviors, performance or competency.

7. Medical Staff members are obligated to follow all UH policies concerning use and disclosure of patient protected health information ("PHI"). In instances where applicable UH policy calls for termination of employment for a person's unauthorized use or disclosure of PHI, such behavior shall also result in termination of that person's Medical Staff appointment and all clinical privileges, regardless of whether that person has an employment relationship with UH. Medical Staff members shall be entitled to due process rights, as set forth in Section 11, for purposes of demonstrating that they did not violate such policy, but they may not challenge the applicability or appropriateness of the policy or argue for a lesser penalty.

C. SUMMARY SUSPENSION

1. Whenever a Member's conduct presents a danger of immediate and serious harm to the life, health or safety of any patient or other individual, the Hospital President or the CMO shall each have the authority to summarily suspend all or a portion of the clinical privileges of a Member, and such suspension shall become effective immediately upon imposition.

2. In the event that all or a portion of the clinical privileges of a Member have been summarily suspended, and within a reasonable time, but not to exceed twenty-one (21) days, the Medical Executive Committee shall convene to consider the summary suspension. The Member shall be notified of the date, time and place of this meeting no less than twenty-four (24) hours prior to the scheduled time. The Member shall be entitled, but not required, to personally appear at the hearing to present his or her position to the Medical Executive Committee. If the hearing contemplated in this Section does not occur within twenty-one (21) days of the imposition of the suspension, then the suspension shall automatically terminate, unless an extension is mutually agreed upon by the Hospital President or CMO of the Hospital and the affected Member.

3. Unless otherwise indicated by the terms of the summary restriction or suspension, the affected Member's patients shall promptly be assigned to another Member by the Department Chair or by the CMO considering, whenever practicable, the desires of the patient in the choice of substitute

Member, and all such substitutions shall be made in the best interests of patient care.

4. After hearing the matter, the Medical Executive Committee may affirm, modify or terminate the summary suspension. If the Medical Executive Committee affirms or modifies the summary suspension in a manner that remains adverse to the Member, the Member shall be notified and shall be entitled to a Fair Hearing in accordance with the provisions of Section XI of these Bylaws. This notice shall constitute notice of the Member's right to request a Fair Hearing under these Bylaws.

D. CONSISTENCY OF ACTION BETWEEN HOSPITAL AND AFFILIATE HOSPITALS

1. By signing and submitting an application for medical staff appointment and/or privileges, the applicant acknowledges that the Hospital is part of a healthcare system with other hospitals within University Hospital Health System ("Affiliate Hospitals") and that information is shared among the Hospital and Affiliate Hospitals. As a condition of appointment and/or grant of privileges, the applicant recognizes and understands that any and all information (including peer review information) relative to his/her appointment and/or privileges that is maintained, received, and/or generated by the Hospital or Affiliate Hospitals may be shared among the Hospital and Affiliate Hospitals. The applicant further understands that this information may be used as part of the respective Hospital's or an Affiliate Hospital's quality assessment and improvement activities and can form the basis for corrective action.

2. So that there is consistency between the Hospital and Affiliate Hospitals regarding corrective action and the status of medical staff appointment and privileges considering that the Hospital and the Affiliate Hospitals are part of the same healthcare system and that the Hospital and the Affiliate Hospitals have agreed to share information regarding appointment and/or privileges, the following automatic actions shall occur:

3. With the exception of an automatic suspension for delinquent medical records, if a Practitioner's appointment and/or privileges are automatically suspended or automatically terminated, in whole or in part, at an Affiliate Hospital(s), the Practitioner's appointment and/or Privileges at this Hospital shall automatically become subject to the same action without recourse to the procedural due process rights set forth in these Bylaws and the Rules and Regulations.

4. If a Practitioner's appointment and/or privileges are summarily suspended or if a Practitioner voluntarily agrees not to exercise privileges while undergoing an investigation at an Affiliate Hospital(s), such summary suspension or voluntary agreement not to exercise privileges shall automatically and equally apply to the Practitioner's appointment and/or Privileges at this Hospital and shall remain in effect until such time as the Affiliate Hospital(s) render(s) a final decision or

otherwise terminate(s) the process.

5. If a Practitioner's appointment and/or privileges are limited, suspended, or terminated at an Affiliate Hospital, in whole or in part, based on professional conduct or clinical competency concerns, the Practitioner's appointment and/or Privileges at this Hospital shall automatically and immediately become subject to the same decision without recourse to the procedural due process rights set forth in these Bylaws and the Rules and Regulations unless otherwise provided in the final decision at the Affiliate Hospital.

6. If a Practitioner resigns his/her medical staff appointment and/or privileges or fails to seek reappointment and/or regrant of Privileges at an Affiliate Hospital(s) while under investigation or to avoid investigation for professional conduct or clinical competency concerns, such resignation shall automatically and equally apply to the Practitioner's Medical Staff appointment and/or Privileges at this Hospital without recourse to the procedural due process rights set forth in these Bylaws and the Rules and Regulations.

E. FAIR HEARING PLAN

1. RIGHT TO A FAIR HEARING

a. Except as otherwise set forth in these Bylaws, the following recommendations or actions shall entitle the affected Member or applicant to a fair hearing:

i. Denial of initial staff appointment;

ii. Denial of reappointment;

iii. Suspension of staff appointment;

iv. Revocation of staff appointment;

v. Denial of a requested modification of staff category;

vi. Reduction in staff category;

vii. Limitation of admitting prerogatives;

viii. Denial of requested clinical privileges;

ix. Reduction in clinical privileges;

x. Suspension of clinical privileges; or

xi. Revocation of clinical privileges.

b. Recommendations of any of these actions by the Medical Executive Committee pursuant to a proposal for Corrective Action under Section XI of these Bylaws shall constitute an action sufficient to entitle a member to a Fair Hearing under these Bylaws.

c. Where applicable, the limitations in Section B(7) above shall apply.

2. NOTICE AND SCHEDULING OF HEARING

a. A Member who is entitled to a Fair Hearing shall promptly be advised of such right. The notice should advise the Member of his or her Medical Staff status pending further action and provide the basis for the adverse decision in order to allow the Member to prepare for the Fair Hearing. Where adverse action was taken pursuant to Section B(7) above, the notice to the practitioner shall advise him/her of the limited scope of the hearing.

b. Any Member seeking to exercise his/her right to a Fair Hearing under these Bylaws shall request such hearing in writing, by sending an official request for a Fair Hearing via certified mail, return receipt requested, addressed to the Hospital President within fifteen (15) days of the date upon which the Hospital provided the notice called for under these Bylaws. Where applicable, a request for hearing must comply with the provisions of Section B(7) above. A Member who fails to make a proper request for Fair Hearing in the manner and timeframe set forth in this paragraph shall be deemed to have waived the right to such hearing and any further review of the action or recommendation giving rise the right to a Fair Hearing under these Bylaws.

c. If the Member properly requests a Fair Hearing, the Member will be provided with a notice by hand delivery or certified mail, return receipt requested, setting forth the place, time and date of the hearing. Reasonable efforts shall be used to schedule the hearing between thirty (30) and forty-five (45) calendar days after the date of the Member's request for a hearing, unless an earlier date is requested by the member and agreed to by the Hearing Committee.

d. At least fourteen (14) days prior to the scheduled date of the Fair Hearing, the Hospital and the affected member shall exchange lists of the witnesses and evidence each intends to introduce or rely upon during the Fair Hearing. Additional witnesses may be

permitted to testify at the hearing at the discretion of the Hearing Committee.

3. THE HEARING COMMITTEE

a. Any Fair Hearing held hereunder shall be conducted in front of a Hearing Committee.

b. The Hearing Committee shall be appointed by the CMO, in consultation with the Medical Executive Committee. The Hearing Committee shall consist of three (3) Members of the Medical Staff. If the request for corrective action substantially involves matters unique to the medical/surgical specialty of the Member who requested the hearing, the Hearing Committee shall, wherever possible, include at least one (1) Member who is a physician from that same specialty. The Members selected to serve on the Hearing Committee shall be impartial and shall not have actively participated in the formal consideration of the matter at any previous level and shall not be engaged in direct economic competition with the affected Member. The fact that an individual is employed by a UH-owned entity, in and of itself, shall not be construed as direct economic competition. If three (3) impartial Members cannot be identified, then practitioners shall be selected from outside the Hospital, in accordance with the requirements set forth above.

c. Each Hearing Committee shall choose from among its number a Presiding Officer, who shall arrange for the conduct of the Committee's administration, act to maintain decorum, and assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The Presiding Officer shall have the authority to determine the order of procedure during the hearing, and shall make all rulings on matters of law, procedure, and the relevance and admissibility of evidence.

d. The CMO shall, after consultation with the parties, also appoint a Counsel to the Hearing Committee. The Counsel shall be an independent attorney at law, shall be free from professional conflicts of interest, and shall have experience in Medical Staff matters. The Counsel shall advise the Hearing Committee generally on the discharge of its functions, and shall draft the findings and conclusions of the Hearing Committee as requested by and in consultation with the Hearing Committee. The Counsel may participate in the deliberations of the Hearing Committee, but may not vote.

4. CONDUCT OF HEARING

a. The hearing shall be conducted in a fair and reasonable manner, but is not subject to any legal rules of evidence or procedure. All participants shall act professionally and respect the process, Hearing Committee and the Counsel to the Hearing Committee.

b. The Presiding Officer shall preside over the hearing, rule upon matters of procedure, and assure that all participants have a reasonable opportunity to present information, maintain decorum, and be responsible for the preservation of exhibits.

c. An accurate record shall be made, which, by agreement of the Hospital and the affected Member, may be made by means of either a stenographic transcript, or a recording device in conjunction with an agreed upon third-party transcription service. The costs of such recording and transcription, if any, shall be born equally by the Member and the Hospital.

d. Either the Hospital or the affected Member, or both, may designate a representative (including legal counsel) to present their case to the Hearing Committee. Such representative shall have the same rights in the hearing as the parties, including the right to present witnesses, examine other participants in the hearing, and, at the discretion of the Hearing Committee, make opening and closing statements.

e. Both the Member and the Hospital shall be entitled, but not required, to submit a written position statement to the Hearing Committee setting forth the basis for the positions to be taken at the Fair Hearing. This written submission shall be no longer than fifteen (15) pages, not inclusive of exhibits, and shall be submitted to the Hearing Committee no less than seven (7) days prior to the scheduled date of the Fair Hearing. Any report submitted to the Hearing Committee under this Section shall also be provided to the Hospital or Member, respectively.

f. In the event that the practitioner has been subjected to a final disciplinary sanction at another UH wholly-owned entity, the existence of such sanction, as well as the complete hearing record relating to that sanction (if any), are admissible as evidence. However, the committee shall not be bound by the findings of the earlier proceeding, and is entitled to give such findings whatever weight it deems appropriate. For purposes of this section, "final disciplinary sanction" refers to any action described in sections B.4(c)(ii) through (v) above which has been imposed after exhaustion or waiver of all available due process rights.

g. At its discretion, the Hearing Committee may call its own witnesses or obtain expert assistance in connection with any matter pending before it, where such assistance is deemed by the Hearing Committee to be necessary to facilitate a full and fair evaluation of the facts presented at the hearing. Any written reports by such experts shall be provided to all parties to the hearing.

h. Both sides are required to prepare their cases so that a hearing shall be concluded after a maximum of twelve (12) hours of hearing, to be completed in no more than three (3) hearing sessions. Under extraordinary circumstances, the Hearing Committee in its sole discretion may depart from this requirement; however, a hearing shall not be extended due to delay, repetition, or lack of appropriate deportment in the course of the presentation of a case by any party.

i. The presence of the affected Member at the Fair Hearing shall be required. If the Member fails to appear at the Fair Hearing, the right to the hearing and to any subsequent appellate review shall be deemed to have been waived; provided, however, that the Hearing Committee, for good cause shown, may, in its sole discretion, continue the hearing. Good cause shall not include any circumstances reasonably avoidable.

j. When a hearing relates to denial of appointment or reappointment to the Medical Staff, or denial of a request for clinical privileges or staff category modification, the practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious. In all other instances, the Hospital shall have the initial obligation to present evidence in support of its action or recommendation, but the practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or action by clear and convincing evidence that the grounds therefor lack any factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious. Where applicable, the scope of the hearing and the burden of proof shall be limited as set forth in Section B(7) above.

5. DECISION OF THE HEARING COMMITTEE

a. As promptly as is reasonably practicable after completion of the hearing and the private deliberations of the Hearing Committee, the Counsel to the Hearing Committee, with the assistance and

approval of the Hearing Committee, shall prepare a written opinion setting forth the decision of the Hearing Committee and its recommendations, if any, including a statement of the basis for the recommendations. The written opinion shall be forwarded, together with all exhibits and, if available in whole or in part, the hearing record (including a copy of the stenographic or recorded record of the hearing), to the Medical Executive Committee and to the Board, as appropriate. A copy of the written opinion also shall be provided to the Hospital and the affected Member.

b. The foregoing procedures for a hearing are intended as guidelines for ensuring the affected Member a fair hearing and are not to be construed as establishing a rigid format for the hearing or action by the Hearing Committee.

6. ACTION OF THE BOARD

a. Within a reasonable time, but in no event later than thirty (30) days after receipt of the report of the Hearing Committee, the Board shall consider the report and affirm, modify or reverse the recommendation or action of the Hearing Committee.

b. In considering the report of the Hearing Committee, the Board shall have the discretion to engage expert assistance (whether in the form of outside reviewing physician expertise or otherwise) to assist in its decision making process.

c. Within a reasonable time, but in no event later than fourteen (14) days after the date of considering the Hearing Committee Report, the Board shall notify both the CMO and the affected Member of its decision, including, where applicable, notice to the Member of his or her right to seek Appellate Review of the decision of the Hearing Committee. The record of the Fair Hearing, including all exhibits, written submissions and any recording of the proceedings shall be returned to the CMO. If the affected Member fails to request an appeal of the Board’s decision in accordance with these Bylaws, then such decision becomes final and concludes the proceedings.

F. APPELLATE REVIEW

1. REQUEST FOR APPELLATE REVIEW

a. Subsequent to a recommendation by the Board to continue or modify an adverse action against a Member, the affected Member is entitled to appellate review. Any Member who has received

notice of the right to appellate review under these Bylaws shall request such appeal in writing, by sending an official request for Appellate Review via certified mail, return receipt requested, addressed to the CMO within fifteen (15) days of the date upon which the Board provided the notice called for under these Bylaws. Any Member who fails to request appellate review in the manner and timeframe set forth in this Section shall be deemed to have waived the right to such appellate review of the action or recommendation giving rise the right to appeal under these Bylaws.

b. Upon receipt of a timely request for appellate review, the CMO shall deliver such request to the Board. The Board shall thereafter arrange and schedule an appellate review, using reasonable efforts to schedule the review between ten (10) and forty-five (45) calendar days from the date of the Board's receipt of the timely request for appellate review. Within a reasonable time, but in no event less than ten (10) calendar days prior to the date of the scheduled appeal, the Board shall provide notice to the Member requesting appellate review via hand delivery or certified mail, return receipt requested, of the date, time and place of the scheduled appellate review.

2. APPELLATE REVIEW COMMITTEE

a. Unless otherwise agreed by the parties, Appellate Review shall be conducted by an Appellate Review Committee ("ARC") composed of at least five (5) individuals, including at least three (3) members of the Board, appointed by the Chair of the Board. There shall also be two (2) members taken from the Medical Staff, appointed by the CMO. The Medical Staff appointees to the ARC shall not have served on the Hearing Committee.

b. At its discretion, the ARC may engage independent legal counsel to assist it in the process of evaluating the appeal.

3. APPELLATE REVIEW PROCEDURE

a. All appellate review shall be taken upon the basis of the available record of the Hearing Committee Report and any materials submitted by the parties to the Hearing Committee (the "Record").

b. The appellant or the appellant's representative (including legal counsel) and the Hospital or its representative (including legal counsel) shall have the right to present a written statement, not to exceed twenty (20) pages in length, and to appear before the ARC

for the purpose of oral argument. Statements and argument shall be confined to the Record.

c. Upon request for appellate review, the appellant shall, subject to any applicable legal privilege, be entitled, upon request to the ARC, and the payment of reasonable reproduction costs, to copies of any documents in the Record.

d. The ARC shall have discretion to set reasonable time limits for Appellate Review hearings, arguments, and written submissions.

4. REPORT OF THE APPELLATE REVIEW COMMITTEE

a. Upon the conclusion of the Appellate Review hearing, the ARC shall, at a time convenient to itself, but in no event more than fourteen (14) calendar days from the date of the conclusion of the Appellate Review hearing, conduct its deliberations outside the presence of the parties.

b. At the conclusion of those deliberations, the ARC shall inform the Board of its recommendation to affirm, modify or reverse the determination of the Fair Hearing Committee.

c. Upon notice of the decision of the ARC, the Board shall, within a reasonable time not to exceed thirty (30) days, take final action to affirm, modify or reverse the recommendation of the ARC. The decision of the Board shall be reduced to writing and shall include a statement of the basis for the decision. The appellant shall be notified by the CMO of the Board's action, and shall be provided with a copy of the Board's decision. The decision of the Board shall be final.

XI. CONFIDENTIALITY, IMMUNITY AND RELEASES

A. AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges within this Hospital, an applicant:

1. authorizes representatives of Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability, qualifications, competence, and conduct;

2. agrees that the applicant will not commence a legal action against the Medical Staff or any department, committee, subdivision or member of the Medical Staff of Hospital, or an employee of Hospital, or the Board or any

Member thereof, for any investigation or action taken in accordance with the provisions of the Bylaws;

3. acknowledges that the provisions of this Section are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges of this Hospital; and

4. agrees and acknowledges that Hospital may confidentially share any information about the Member, including, but not limited to credentialing, privileging, peer review, and/or disciplinary information about the applicant, with any other University Hospital Health System hospital or entity regardless of whether that information has been forwarded to the Ohio State Medical Board or the National Practitioner Data Bank.

B. PEER REVIEW

To fulfill its responsibility for the quality and safety of patient care, the Medical Staff conducts peer review exclusively according to its standards and processes as set forth in these Bylaws.

1. PEER REVIEWERS

a. Duty of Members

Members have a duty to serve as peer reviewers, to cooperate in any and all phases of peer review of the services they provide to patients in the Hospital, and to otherwise participate in peer review. A member's unreasonable refusal to serve on peer review committees or otherwise provide reasonably requested peer review services, or to cooperate with peer review of the member's practices or conduct can result in corrective action under these Medical Staff Bylaws. No Medical Staff member is excluded from serving as a peer reviewer because he/she is or is not a hospital employee, has or does not have a contract with the hospital or practices a particular specialty.

b. Conflicts of Interests

If a member of a committee is not a disinterested or impartial party for the purpose of the peer review, he/she shall disqualify him/herself and the Medical Staff President, in consultation with the Chief Medical Officer or the Hospital President, shall appoint a replacement.

Individuals involved in peer review activities shall not have an economic interest in and/or a conflict of interest with the subject of the peer review activity. Impartial peer would exclude individuals with blood relationships, employer/employee relationships, or other potential conflicts that might prevent the individual from giving an impartial assessment, or give the appearance of the potential of bias for or against the subject of the peer review. The fact that an individual is employed by a physician practice group shall not, in and of itself, constitute a conflict of interest.

c. Indemnification and Immunity

Hospital shall indemnify, defend (or pay the cost of defending) and hold each representative of the Medical Staff and Hospital harmless from liability to an applicant or member for damages or other relief for any good faith action taken or statements or recommendations made within the scope of his/her duties as a representative of the Medical Staff or Hospital. Each representative of the Medical Staff and Hospital and all third parties shall be exempt as mandated by Ohio Revised Code Sections 2305.24 et seq. and 42 U.S.C. 11111, from liability to an applicant or a Member for damages for providing information to a representative of the Medical Staff or Hospital concerning such individual who is, or has been, an applicant to the Staff or Member or who did, or does, exercise clinical privileges or provide services at this Hospital.

d. Practice Committees

The Practice Committees of the Medical Staff Departments and other Medical Staff committees, such as the Medical Executive Committee and Credentials Committee, conduct peer review and serve as medical peer review committees. It is expected that Medical Staff Departments which do not have a formal practice committee as listed in Article IX shall conduct their peer review as part of their department meetings. Those portions of the department meetings dedicated to peer review are protected by all Federal and State of Ohio peer provisions.(7) All such committees and their members comply with the requirements of these Bylaws, including Bylaws provisions regarding conflict of interest, processes, training and confidentiality, as well as relevant Hospital policies. Divisions/departments such as those with a limited number of members, those consisting of a single group practice, contracted services, or system service lines may delegate

peer review responsibilities with the Medical Executive Committee's consent. The Medical Executive Committee may request the delegated entity to create policies related to the divisions/departments' peer review process for the Medical Executive Committee's approval.(4) Refer to the Medical Staff policies and procedures related to peer review.(6)External Peer Review

External peer review may be used to inform Medical Staff peer review as delineated under these Bylaws.

The Credentials Committee or the Medical Executive Committee, upon request from a Department or upon its own motion, in evaluating or investigating an applicant, privileges holder, or member, may obtain external peer review in the following circumstances:

i. Committee or department review(s) that could affect an individual's membership or privileges do not provide a sufficiently clear basis for action;

ii. No current Medical Staff member can provide the necessary expertise in the clinical procedure or area under review;

iii. To promote impartial peer review;

iv. In departments limited by an exclusive contract to a single employer or group;

v. Where, in the opinion of the Medical Staff President, in consultation with the Chief Medical Officer or the Hospital President, it is in the best interest of the Hospital to conduct external review.

2. PURPOSE AND STANDARDS OF PEER REVIEW

a. Purpose

Patient safety and quality of care must be the goal. Peer review is not used as punishment or retribution.

b. Medical Staff Standards

Each department and section establishes and updates standards of care to be met by each professional holding privileges, based on generally accepted clinical guidelines and practices, including criteria for measuring members' compliance with the standards set and triggers for corrective action. Standards and any updates to the standards are reviewed and adopted by the Medical Executive Committee. Standards are available at all times to all members.

3. PROTECTIVE ACTION

At any point in the process of peer review, a member or privileges holder may be referred to the Wellness Committee or may, in those extreme conditions defined in these Bylaws, be subject to summary suspension to protect patients and promote safety.

4. TRIGGERING PEER REVIEW

a. Initial Privileges

All privileges initially granted to new members, held as temporary privileges, or granted as additional privileges to an existing member, are subject to focused peer review (FPPE(1)) to validate the grant of privileges. FPPE may include, but not be limited, to the following:(1)

b. Proctoring

Proctors are assigned from the Department Practice Committee by its chair. The proctor reports to the Committee in writing and includes patient safety, professional competence or conduct issues. At the end of the evaluation period, or sooner if deviations from standards or other concerns warrant, the Department Chairperson assesses proctoring reports as part of the Practice Committee evaluation.

c. Other Types of Review

In addition to proctoring or, in circumstances in which proctoring is not suitable, instead of proctoring, the Practice Committee uses

chart review, practice pattern evaluation, external review, or other appropriate tools to evaluate initial privileges.

d. Ongoing Peer Review (OPPE(1))

e. Members' Professional Practices

The practices of members and others holding privileges are consistently evaluated according to the standards developed by the Department and adopted by the Medical Executive Committee.

f. Concern/Event/Issue/Incident Evaluation

Concerns raised by regular section or department peer review committee activity are evaluated in light of pre-event occurrences and systemic factors. Complaints or other concerns raised outside of peer review, including self-reported incidents, are referred to the appropriate section or department peer review committee.

The subject of review is included early in the review process and as appropriate throughout, to promote the sharing of information.

g. The imposition or continuation of a summary suspension or restriction is a precaution only and does not constitute a finding of fault on the part of the individual and shall not give rise to a report to the National Practitioner Data Bank unless it exceeds 30 days(1) provided that this shall not prohibit the reporting of a final adverse action following the policies and procedures set forth below.

5. OUTCOMES OF PEER REVIEW

a. Department Chairperson Review

At the end of the evaluation period, or sooner if deviations from standards or other concerns warrant, the Department Chairperson assesses review reports as part of the Practice Committee evaluation.

b. Recommendations for System Improvement

The Practice Committee reports to the Department and can recommend, for referral, changes in systems operating in the Department, Medical Staff or Hospital to improve patient safety and care.

c. Recommendations for Members

The Practice Committee report can instead, or also, make recommendations regarding the member, if warranted by the information gathered. All recommendations for improvement are supported by Committee findings and are reported to the member and the Department Chairperson, specifying the standards at issue, deviations identified and steps that should have been taken and are recommended for future compliance and remediation.

The Practice Committee review is considered by the Department and acted upon as part of its peer review responsibilities. If appropriate under Department standards, performance monitoring, corrective action or other measures are implemented or recommended. The Department can request the Medical Executive Committee to initiate investigation or, if the information gathered to date warrants, request the Medical Executive Committee to summarily suspend the member, recommend restriction of privileges or take other appropriate corrective action.

d. Data Bank Reporting

No peer review activity, actions or recommendations as described in this Article are reportable to the National Practitioner Data Bank except where required by applicable law

C. CONFIDENTIALITY OF INFORMATION

1. GENERAL

Medical Staff, department, division, or committee minutes, files, and records, including information regarding any member or applicant to this Medical Staff, shall be confidential as mandated by Ohio Revised Code Section 2305.24 et seq. Dissemination of such information and records shall only be made where expressly required by law, or pursuant to officially adopted policies of the Medical Staff, which at all times shall be consistent with Ohio Revised Code Section 2305.24 et seq. Disclosure of information may only be done as required by law.

2. BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review and consideration of the qualifications of Members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff departments, divisions, or committees, except in conjunction with another hospital, professional society, or licensing authority, is outside appropriate standards of conduct for the Medical Staff and may violate provisions of the Ohio Revised Code, imposing civil liability. If it is determined that such a breach has occurred, the Medical Executive Committee, or the Board, may undertake such corrective action as it deems appropriate.

D. IMMUNITY FROM LIABILITY

1. FOR ACTION TAKEN

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

2. FOR PROVIDING INFORMATION

Each representative of the Medical Staff and Hospital and all third parties shall be exempt as mandated by Ohio Revised Code Sections 2305.24 et seq. and 42 U.S.C. 11111, from liability to an applicant or a Member for damages for providing information to a representative of the Medical Staff or Hospital concerning such individual who is, or has been, an applicant to the Staff or Member or who did, or does, exercise clinical privileges or provide services at this Hospital.

E. ACTIVITIES AND INFORMATION COVERED

1. ACTIVITIES

The confidentiality and immunity provided by this Section shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

a. applications for appointment, reappointment, or clinical privileges;

b. periodic reappraisals for appointment and clinical privileges;

c. corrective action, including summary suspension;

d. hearings and appellate reviews;

e. performance improvement activities;

f. utilization reviews;

g. participation in the UH or Hospital's delegated credentialing program;

h. other department, or division, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

i. peer review organizations, State Medical Board of Ohio and similar reports.

F. RELEASES

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

XII. GENERAL PROVISIONS ON GOVERNANCE

A. RULES AND REGULATIONS

The Medical Staff shall initiate and adopt such Rules and Regulations as may be necessary to implement more specifically the principles in these Bylaws and for the proper conduct of its work. The Rules and Regulations are subject to the approval of the Board of Directors, which approval shall not be unreasonably withheld. The Rules and Regulations shall be reviewed periodically by the Bylaws Committee and be revised to comply with current Medical Staff practices. Changes may be proposed in writing by any Medical Staff member or by the Bylaws Committee, MEC, the Board of Directors or at any regular meeting of the Medical Staff. Changes to the Rules and Regulations recommended by the Bylaws Committee shall be reviewed and evaluated by the MEC. Any modification(s) to the change(s) made by the MEC will be referred to the Bylaws Committee to insure there is no conflict with the current Bylaws and Rules and Regulations prior to presentation to the Medical Staff. Changes to the Rules and Regulations shall be submitted to the Medical Executive Committee for review and evaluation, and shall be adopted by a majority vote of its members present and voting. Such changes shall become effective when approved by the Board of Directors. If there is a conflict between the Bylaws and the Rules and Regulations, the Bylaws shall prevail. Applicants and Members of the Medical Staff shall be governed by such rules and regulations as are properly adopted..

B. DUES OR ASSESSMENTS

The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of Medical Staff membership, and to determine the manner of expenditure of such funds received.

C. CONSTRUCTION OF HEADINGS AND TERMS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. These Bylaws apply with equal force to both sexes wherever a gender term is used.

D. AUTHORITY TO ACT

Any Member or Members who act in the name of this Medical Staff without proper authority shall be subject to disciplinary action. Action will be recommended to the Board by the Medical Executive Committee.

E. NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests required or permitted to be delivered should be in writing, properly sealed, and sent through the United States Postal Service, first class postage prepaid or an equivalent, alternative delivery mechanism including, but not limited to, hand delivery, Federal Express, UPS etc. Mailed notices to a member, applicant, or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff office of the Hospital.

F. REPORTS

1. REPORT FORMAT

In these Bylaws, whenever a report is requested, required, or recommended, the format of the report may be as determined by the reporting Medical Staff Member or the Medical Staff committee. That is, the report may take the form of minutes of a committee meeting; may be a separately constituted report; or may be a verbal report at a subsequent meeting which is incorporated into the minutes of or incorporated in a report emanating from a subsequent meeting.

2. PEER REVIEW REPORTS

Whenever a report of a peer review process is prepared it should include minority opinions, if available, and the views of the Medical Staff Member whose activity is being reviewed.

XIII. ADOPTION AND AMENDMENT OF BYLAWS

A. PROCEDURE

Upon the request of the CMO, the Medical Executive Committee, the Bylaws Committee, or upon timely written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the amendment, or repeal of these Bylaws. Such action shall initially be taken by the Medical Executive Committee at a regular or special meeting. If approved by the Medical Executive Committee, notice of the proposed amendment shall be provided to all Members eligible to vote. The Members eligible to vote must receive ten (10) days' electronic notice of any amendments to the Medical Staff Bylaws. The notice must include an electronic ballot through which each eligible Member may vote to recommend adoption, amendment, or repeal of the Medical Staff Bylaws within the ten (10) day notice period. If unforeseen circumstances necessitate use of a written notice and physical ballot process, the MEC may adopt such process in its reasonable discretion.

B. ACTION ON BYLAW CHANGE

The change shall require an affirmative vote of a majority of the Members voting. Proxy ballots shall not be allowed.

C. APPROVAL

Bylaw changes adopted by the Medical Staff shall become effective following approval by the Board, which approval shall not be withheld unreasonably, or automatically within ninety (90) days if no action is taken by the Board.

D. EXCLUSIVITY

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

E. DISTRIBUTION OF BYLAWS

All current and new Medical Staff members shall be given a copy of these Bylaws and asked to acknowledge that they have received, read, and understand them.

XIV. COMMITTEES

A. GENERAL PROVISIONS

1. TERM OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed for a term of two years. Each member shall serve until the end of this period or until his/her successor is appointed, unless the member resigns or is removed from the committee.

2. REMOVAL

The Medical Executive Committee may remove any committee member for good cause, including, but not limited to: where the member ceases to be in good standing of the Medical staff, or the member, suffers a loss or significant limitation of practice privileges.

3. VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filed in the same manner in which an original appointment to that committee is made.

B. MEDICAL EXECUTIVE COMMITTEE

1. COMPOSITION

a. The Medical Executive Committee shall consist of the following individuals:

i. the officers of the Medical Staff;

ii. the Chairs of the Departments of the Medical Staff;

iii. the immediate past President;

iv. ex-officio members of the committee shall include be the the Hospital President, the Chief Medical Officer, the Chief Nursing Officer, and the Chairman of the Board or his/her designee; and

v. three (3) at large members from the active voting Medical Staff.

b. The President shall chair the Medical Executive Committee, and may require committee chairs and/or Division chiefs to appear and report as necessary.

2. DUTIES.

The duties of the Medical Executive Committee shall include, but not be limited to:

a. representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;

b. coordinating and implementing the professional and organizational activities and policies of the Medical Staff;

c. receiving and acting upon reports and recommendations from Medical Staff departments, divisions, committees, and assigned activity groups;

d. recommending action to the Board on Medical Staff matters;

e. recommending to the Board the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality assurance activities and mechanisms of the Medical Staff, as well as other matters relevant to the operation of an organized Medical Staff;

f. evaluating the medical care rendered to patients in the Hospital;

g. participating in the development of all Medical Staff policy, Hospital policy, practice, and planning;

h. reviewing the qualifications, credentials, performance and professional competence and character of applicants and staff members and making recommendations to the Board regarding staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action;

i. taking reasonable steps to promote professional conduct and competent clinical performance on the part of all members including the initiation of and participation in Medical Staff corrective or review measures when warranted;

j. investigating any breach of ethics that may be reported;

k. taking reasonable steps to develop continuing education activities and programs for the Medical Staff;

l. designating or creating 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 those committees by the President of the Medical Staff;

m. reporting to the Medical Staff at each regular staff meeting;

n. assisting in the obtaining and maintaining of accreditation;

o. developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster;

p. appointing 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;

q. providing oversight for quality assessment and improvement, risk management and utilization activities of the Medical Staff; and

r. approving sources of patient care provided outside the hospital.

4. MEETINGS

The Medical Executive Committee shall meet as often as necessary, but at least ten times per year, and shall maintain a record of its proceedings and actions. A quorum at the Medical Executive Committee shall consist of fifty percent (50%) of the voting members of the committee.

C. CREDENTIALS COMMITTEE

1. COMPOSITION

The Credentials Committee consists of five (5) members. The chair shall be appointed by the Chief Medical Officer to a term of three (3) years, but may be removed at any time, for any reason, by the CMO. Two (2) members shall be appointed by the president of Medical Staff, to a term of three (3) years. In addition, chairs of departments of medicine and surgery shall serve as full voting members. The chief medical officer shall serve in an advisory role, without vote. The president of Medical Staff and Hospital President may attend the meeting as ex officio without vote.

2. DUTIES

The Credentials Committee performs the following functions both for initial applications and renewal applications for Medical Staff membership:

a. The Credentials Committee shall review the application, evaluate and verify the supporting documentation, the department Chair's report and recommendations, and other relevant information. The Credentials Committee may elect to interview the applicant and seek additional information.

b. The Credentials Committee shall transmit to the Medical Executive Committee its recommendations as to appointment and, if appointment is recommended, as to the membership category,

department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment.

c. If the Credentials Committee determines that substantive matters are jeopardizing the applicant, the Credentialing Committee shall so notify the applicant and provide him with an opportunity to respond to the matter or such other action as is appropriate under the circumstances.

d. The Credentialing Committee may also recommend that the Medical Executive Committee defer action on the application for a specified period of time based upon specific reasons as enumerated by the Committee.

e. An applicant's complete application may be forwarded to the Medical Executive Committee without a Credentials committee review if the application is a clean application as defined by the absence of:

i. An involuntary termination of Medical Staff membership at another institution;

ii. An involuntary limitation, reduction, denial, or loss of clinical privileges at any institution; or

iii. A final judgment adverse to the applicant in a professional liability action.

iv. Any current challenge or previously successful challenge to licensure or registration.

3. MEETINGS

The Credentials Committee meets once a month. To ensure that recommendation for approval of new members or reappointments is ready for Executive committee's review, the Committee meets one week before the Executive committee meeting. Special additional meeting may be called by chair. Chair of Credentials Committee attends executive committee meeting without vote.

D. ADDITIONAL COMMITTEES

Additional Committees of the Medical Staff shall be established to provide for the ongoing monitoring of the Medical Staff function and to assure the provision of quality care in the Hospital. These committees will be established by the Medical Executive Committee as a standing or as an ad hoc committee as the need arises.

Approved by Board
November 19, 2025