REPLACE EXHAUST FANS IN KITCHEN AREA

Humboldt General Hospital
Board of Trustees Meeting
17 December 2019
Agenda item:

Executive Summary – Replace the kitchen hood and the dishwasher exhaust fan and relocate them to the roof for maintenance access.

Request

Approve to replace the hood and dishwasher exhaust fans and relocated them to the roof.

Rational

These exhaust fans were installed back in the 70's and are located in the attic space.

Maintenance on these fans is near impossible, so as part of the kitchen area remodel.

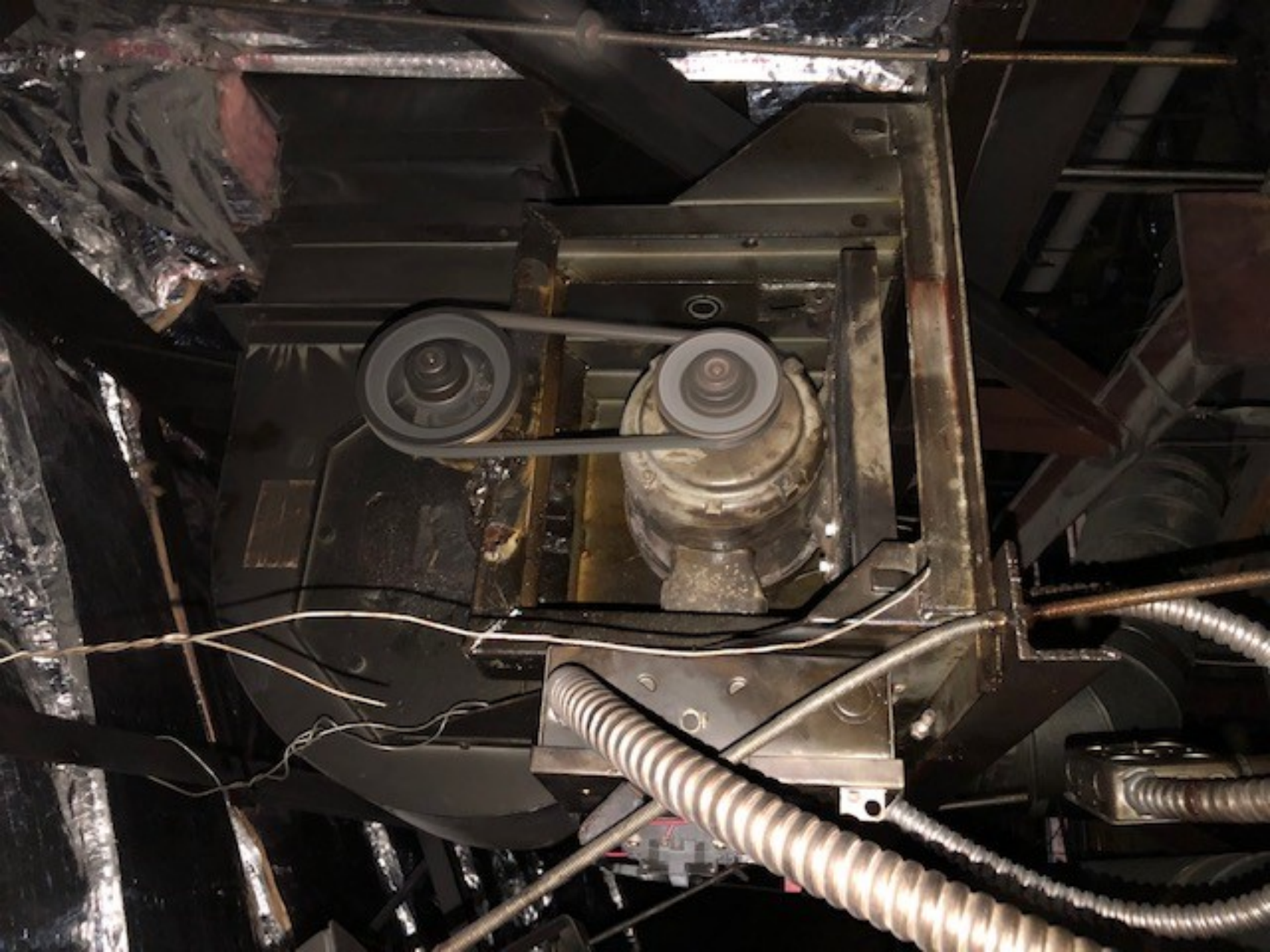
Moving these fans to the roof makes them much easier to service and with the new Makeup air unit.

Recommendation

Recommend Board to approve replacing the exhaust fans and moving them to the roof for access

Point of Contact: Duane Grannis, Plant Facility & Safety Director

ON
OFF



HUMBOLDT GENERAL HOSPITAL

MEDICAL STAFF BYLAWS

Proposed Changes

August 20, 2019

TABLE OF CONTENTS

PAGE

PREAMBLE 1

DEFINITIONS 1

ARTICLE 1: DESCRIPTION OF ORGANIZATION 3

1.01 DESCRIPTION 3

1.02 PURPOSES AND RESPONSIBILITIES 3

ARTICLE 2: MEDICAL STAFF MEMBERSHIP 4

2.01 NATURE OF MEDICAL STAFF MEMBERSHIP 4

2.02 QUALIFICATIONS FOR MEMBERSHIP 4

2.03 PARTICULAR QUALIFICATIONS 5

2.04 EFFECT OF OTHER AFFILIATIONS 5

2.05 NONDISCRIMINATION 6

2.06 ADMINISTRATIVE AND CONTRACT PRACTITIONERS 6

2.07 PHYSICIANS IN TRAINING 6

2.08 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP 6

2.09 WAIVER OF QUALIFICATIONS 8

ARTICLE 3: CATEGORIES OF THE MEDICAL STAFF 8

3.01 CATEGORIES 8

3.02 ACTIVE STAFF 8

3.03 PROVISIONAL STAFF 8

3.04 COURTESY STAFF 9

PAGE

3.05 CONSULTING STAFF 9

3.06 ALLIED HEALTH STAFF 9

ARTICLE 4: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT 9

4.01 APPLICATION FOR INITIAL APPOINTMENT 9

4.02 DURATION OF APPOINTMENT 14

4.03 REAPPOINTMENT PROCESS 15

4.04 REQUESTS FOR MODIFICATION OF APPOINTMENT 16

4.05 REAPPLICATION AFTER ADVERSE DECISION 17

4.06 CONFIDENTIALITY; IMPARTIALITY 18

ARTICLE 5: DETERMINATION OF CLINICAL PRIVILEGES 18

5.01 EXERCISE OF PRIVILEGES 18

5.02 DELINEATION OF PRIVILEGES IN GENERAL 18

5.03 CONSULTATIONS 19

5.04 CREDENTIALING OF ALLIED HEALTH PROFESSIONALS 19

5.05 LOSS OF SPONSOR 20

5.06 CONFIDENTIALITY; IMPARTIALITY 21

5.07 TEMPORARY PRIVILEGES AND LOCUM TENENS 21

5.08 PROCTORING 22

ARTICLE 6: CORRECTIVE ACTION 23

6.01 COLLEGIAL INTERVENTION 23

6.02 DISRUPTIVE BEHAVIOR 24

PAGE

6.03 EVALUATION OF THE NEED FOR CORRECTIVE ACTION 28

6.04 SUMMARY SUSPENSION 31

6.05 AUTOMATIC SUSPENSION AND TERMINATION 32

6.06 LEAVES OF ABSENCE 35

ARTICLE 7: "FAIR HEARING PLAN" (INTERVIEWS, HEARINGS AND APPELLATE REVIEW) 36

7.01 INTERVIEWS 36

7.02 HEARINGS AND APPELLATE REVIEW 36

7.03 EXHAUSTION OF REMEDIES 38

7.04 INITIATION OF HEARING 38

7.05 APPOINTMENT OF HEARING COMMITTEE 40

7.06 ADDITIONAL NOTICES 41

7.07 EXCHANGE OF WITNESS LISTS; DISCOVERY; PREHEARING MOTIONS 42

7.08 HEARING PROCEDURE 43

7.09 HEARING COMMITTEE REPORT AND FURTHER ACTION 46

7.10 INITIATION AND PREREQUISITES OF APPELLATE REVIEW 47

7.11 APPELLATE REVIEW PROCEDURE 48

7.12 FINAL DECISION OF THE GOVERNING BODY 50

7.13 GENERAL PROVISIONS 50

ARTICLE 8: REVIEW OF BYLAWS, RULES AND REGULATIONS, AND POLICIES 52

8.01 REQUEST FOR REVIEW 52

8.02 BYLAWS COMMITTEE REVIEW 52

PAGE

8.03 MEDICAL EXECUTIVE COMMITTEE ACTION 52

8.04 LIMITATION ON FREQUENCY OF REVIEW 53

8.05 TIME FRAMES 53

ARTICLE 9: MEDICAL STAFF OFFICERS 53

9.01 MEDICAL STAFF OFFICERS - GENERAL PROVISIONS 53

9.02 THE CHIEF OF STAFF 55

9.03 VICE-CHIEF OF STAFF (VICE-CHIEF) 57

9.04 TREASURER 58

ARTICLE 10: COMMITTEES 59

10.01 MEDICAL EXECUTIVE COMMITTEE 59

10.02 OTHER MEDICAL STAFF COMMITTEES , GENERAL, PROVISIONS 62

10.03 CREDENTIALS COMMITTEE 63

10.04 MEDICAL STAFF PEER REVIEW COMMITTEE 64

ARTICLE 11: MEETINGS 64

11.01 GENERAL STAFF MEETINGS 64

11.02 PROVISIONS COMMON TO ALL MEETINGS 64

11.03 COMMITTEE MEETINGS 66

11.04 ATTENDANCE REQUIREMENTS 66

ARTICLE 12: IMMUNITY AND RELEASES 67

12.01 CONFIDENTIALITY, IMMUNITY AND RELEASES 66

12.02 IMMUNITY FROM LIABILITY 67

12.03 ACTIVITIES AND INFORMATION COVERED 69

PAGE

12.04 RELEASES 69

12.05 CUMULATIVE EFFECT 70

ARTICLE 13: GENERAL PROVISIONS 70

13.01 STAFF RULES AND REGULATIONS 70

13.02 MEDICAL STAFF POLICIES 70

13.03 MEDICAL STAFF PARTICIPATION IN HOSPITAL DELIBERATIONS 70

13.04 PROFESSIONAL LIABILITY INSURANCE 70

13.05 FORMS 70

13.06 HISTORIES AND PHYSICALS 71

ARTICLE 14: ADOPTION AND AMENDMENT OF BYLAWS 73

14.01 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY 73

14.02 METHODOLOGY 73

14.03 MEDICAL STAFF DOCUMENTS 74

HUMBOLDT GENERAL HOSPITAL

MEDICAL STAFF BYLAWS

PREAMBLE

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Humboldt General Hospital; to provide a framework for self-government that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care; to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive to those purposes; and to account to the Governing Body for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with applicants to and members of the Medical Staff. This current version makes all previous versions and amendments null and void.

DEFINITIONS

1. "ALLIED HEALTH PROFESSIONAL" or "AHP" means an individual, other than a licensed physician, dentist or podiatrist, who exercises independent judgment within the areas of his/her professional competence and the limits established by the Governing Body, the Medical Staff and the applicable State Practice Acts, who is qualified to render direct or indirect medical, dental or podiatric care under the supervision or direction of a Medical Staff member possessing privileges to provide such care in the hospital, and who may be eligible to exercise privileges and prerogatives in conformity with the rules adopted by the Governing Body, these Bylaws, and the Medical Staff Rules and Regulations. The term also includes clinical psychologists who are granted privileges by the Board but who do not require supervision by a Medical Staff member.

2. "APPELLATE REVIEW BODY" means the group designated pursuant to Article 7 of these Bylaws to hear a request for appellate review properly filed and pursued by a practitioner or the Medical Executive Committee.

3. "BOARD" means the Board of Trustees of the Hospital, which has the overall responsibility for the Hospital, or its designated committee. The Board is also referred to as the "Governing Body."

4. "BOARD CERTIFICATION" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties ("ABMS"), the American Osteopathic Association ("AOA"), the American Board of Oral and Maxillofacial Surgery, a specialty board recognized by the American Dental Association, or the American Board of Podiatric Surgery, upon a practitioner, as applicable, who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice.

5. "CHIEF EXECUTIVE OFFICER" or "CEO" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

6. "CHIEF OF STAFF" means the chief elected officer of the Medical Staff.

7. "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific patient care services, for which the Medical Staff leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.

8. "CORE PRIVILEGES" or "CORE" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and that have been determined by the Medical Staff leaders and Board to require closely related skills and experience.

9. "DATE OF RECEIPT" of any notice or other communication shall be deemed to be the date such notice or communication was delivered personally to the required addressee or, if sent by mail, 72 hours after being deposited, postage prepaid, in the United States mail. (See also, definition of "NOTICE").

10. "HEARING COMMITTEE" means the committee appointed pursuant to Article 7 of these Bylaws to hear a request for an evidentiary hearing properly filed and pursued by a Medical Staff member.

11. "HOSPITAL" means Humboldt General Hospital, including any sites that are treated as provider-based by the Centers for Medicare and Medicaid Services ("CMS").

12. "HOSPITAL REPRESENTATIVE" means the Governing Body, its individual Trustees and committee members; the Chief Executive Officer, and other Hospital employees; the Medical Staff, all Medical Staff officers and/or committee members having responsibility for collecting or evaluating the applicant's credentials; and any authorized representative of any of the foregoing.

13. "MEDICAL STAFF" or "STAFF" means those physicians (M.D. or D.O.), dentists and podiatrists who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.

14. "MEDICAL STAFF YEAR" means the period from January 1 through December 31.

15. "NOTICE" means a written communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the Hospital. "SPECIAL NOTICE" means written communication sent by certified or registered mail, return receipt requested. (See also, definition of "DATE OF RECEIPT").

16. "PARTIES" mean the Medical Staff member who requested the hearing or appellate review and the body or bodies upon whose adverse action a hearing or appellate review request is predicated.

17. "PHYSICIAN" means an individual with an M.D. or D.O. degree who is currently licensed to practice medicine.

18. "PRACTITIONER" means, unless otherwise expressly limited, any physician (M.D. or D.O.), dentist, podiatrist or Allied Health Professional holding a current license to practice within the scope of his/her license. By way of example and not limitation, Allied Health Professionals are not "practitioners" for purposes of Article 7 of these Bylaws (Fair Hearing Plan).

19. "SPECIAL PRIVILEGES" means privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.

20. "UNASSIGNED PATIENT" means any individual who comes to the Hospital for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

21. Timeframes will always refer to calendar dates unless otherwise stated.

ARTICLE 1: DESCRIPTION OF ORGANIZATION

1.01 DESCRIPTION

(a) The Medical Staff organization is structured as follows: The members of the Medical Staff are assigned to a staff category depending upon time at the hospital and nature of practice at the hospital. All new Medical Staff members are assigned to the Provisional Staff. Upon satisfactory completion of the provisional period, the Medical Staff members are assigned to one of the following staff categories: Active, Provisional, Courtesy, or Consulting. Allied Health Professionals will be assigned to the Allied Health staff category. Only Active staff members are eligible to vote. Active staff who meet additional qualifications listed later may hold office in this organization.

(b) There are also Medical Staff committees that perform staff-wide responsibilities and that oversee related activities.

(c) Overseeing all of this is the Chief of Staff and the Medical Executive Committee (MEC) whose duties are described later in these bylaws.

1.02 PURPOSES AND RESPONSIBILITIES

The purposes of this organization are to provide a mechanism for organization and coordination of practitioners at the Hospital, and to discharge the responsibilities and prerogatives entrusted by law and custom to an organized Medical Staff by adopting Bylaws and Rules and Regulations to establish a framework for self-governance of the Medical Staff with respect to the professional work performed in the Hospital and to provide for accountability to the Governing Body.

ARTICLE 2: MEDICAL STAFF MEMBERSHIP

2.01 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff and/or clinical privileges shall be extended to, and may be maintained by only those professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. A practitioner, including those in a medical-administrative position by virtue of a contract with the Hospital, shall admit or provide medical or health related services to patients in the Hospital only if he/she has been granted clinical privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted by the Governing Body in accordance with these Bylaws.

2.02 QUALIFICATIONS FOR MEMBERSHIP

(a) A physician, dentist or podiatrist must satisfy the following threshold criteria to be eligible to apply for Medical Staff membership:

(1) be licensed in the State of Nevada and (if practicing clinical medicine, dentistry or podiatry) have a federal DEA number;

(2) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the AOA in the specialty in which the applicant seeks clinical privileges, a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association, or a podiatry surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association. (This requirement is applicable only to those individuals who apply for initial staff appointment after the date of adoption of this Policy (2011). All individuals appointed previously will be governed by the training requirements in effect at the time of their appointments.);

(3) be board certified in their primary area of practice at the Hospital. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last four years will be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within four years from the date of completion of their residency or fellowship training. This requirement is applicable only to those individuals who apply for initial staff appointment after the date of adoption of this Policy (2011). All individuals appointed previously will be governed by the board certification requirements in effect at the time of their appointments.

(4) demonstrate recent clinical activity of at least 20 hours per week in their primary area of practice during at least two of the last five years, and have actively practiced for an average of at least 20 hours per week in his/her field for 18 of the previous 24 months

(or have completed a 12-month residency within the previous 18 months), and have practiced in an acute care hospital at least two of the previous five years; and

(5) have liability insurance coverage in minimum limits of $1,000,000 per occurrence/ $3,000,000 annual aggregate or as set by the Medical Executive Committee and the Governing Body and coverage is consistent with privileges requested.

(b) A physician, dentist or podiatrist must also satisfy the following requirements to be appointed to and maintain membership on the Medical Staff:

(1) be able to verify his/her compliance with the provisions of Section 2.02(a); and

(2) document his/her:

a. adequate experience, education and training for the clinical privileges being requested, as set forth in applicable policies or delineations of privileges; and

b. current professional competence, good judgment and adherence to the lawful ethics of his/her profession.

2.03 PARTICULAR QUALIFICATIONS

(a) Physicians. An applicant for physician membership in the Medical Staff must hold an M.D. or D.O. degree issued by a medical or osteopathic school recognized by the Council on Postsecondary Accreditation, and must also hold a certificate to practice medicine issued by the Medical Board of Nevada or the Board of Osteopathic Examiners of the State of Nevada which is valid, current, and unsuspended.

(b) Dentists. An applicant for dental membership in the Medical Staff must hold a D.D.S. or equivalent degree issued by a dental school recognized by the Council on Postsecondary Accreditation, and must also hold a certificate to practice dentistry issued by the Board of Dental Examiners of Nevada which is valid, current, and unsuspended.

(c) Podiatrists. An applicant for podiatric membership in the Medical Staff must hold a D.P.M. degree issued by a podiatric medicine school recognized by the Council on Postsecondary Accreditation, and must hold a certificate to practice podiatry issued by the Medical Board of Nevada which is valid, current, and unsuspended.

2.04 EFFECT OF OTHER AFFILIATIONS

No practitioner shall be entitled to membership on the Medical Staff merely because he/she holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because he/she had, or presently has, staff membership or privileges at another health care facility.

2.05 NONDISCRIMINATION

Medical Staff membership or particular clinical privileges shall not be denied on the basis of race, color, national origin, ancestry, religious creed, age, disability, sex, sexual orientation, gender identity or expression, or familial status.

2.06 ADMINISTRATIVE AND CONTRACT PRACTITIONERS

(a) A practitioner employed by or contracting with the Hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the Hospital and to the terms of his/her contract or other conditions of employment, and need not be a member of the Medical Staff.

(b) A practitioner contracting with the Hospital in an administrative capacity who also wishes to perform clinical duties must be granted Medical Staff appointment and clinical privileges pursuant to the procedures described in these Bylaws.

2.07 PHYSICIANS IN TRAINING

Physicians in training will not be granted appointment to the Medical Staff or clinical privileges. The program director, clinical faculty, or attending staff member will be responsible for the direction and supervision of the on-site or day-to-day patient care activities of each trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, or training protocols approved by the Hospital. The applicable program director will be responsible for verifying and evaluating the qualifications of each physician in training.

2.08 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP Each member of the Medical Staff shall:

(a) Provide his/her patients with care of the generally recognized professional level of quality and efficiency;

(b) Abide by the Medical Staff Bylaws and Rules and Regulations and standards, policies, and rules of the Hospital and the Medical Staff;

(c) Abide by all applicable laws and regulations of governmental agencies;

(d) Discharge such Staff, committee, and service functions for which he/she is responsible by appointment, election, or otherwise;

(e) Prepare and complete in timely manner the medical and other required records for all patients he/she admits or in any way provides care to in the Hospital;

(f) Abide by the ethical principles of his/her profession and the Hospital which include, but not by way of limitation, a pledge to:

1. Refrain from fee splitting or other inducements relating to patient referral;

2. Provide for continuous care of his/her hospitalized patients, without regard for the patient's race, color, national origin, ancestry, religious creed, age, disability, sex, sexual orientation, gender identity or expression, familial status, ability to pay, or source of payment;

3. Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a practitioner who is not qualified to undertake this responsibility and who is not adequately supervised; and

4. Seek consultation as required in the Medical Staff Rules and Regulations, or whenever warranted by the patient's condition.

(g) Actively participate in and regularly cooperate with the Medical Staff in assisting the Hospital to fulfill its obligations related to patient care, including but not limited to patient care audits, peer review, utilization review, quality evaluation and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time;

(h) Participate in Continuing Medical Education programs appropriate to his/her specialty. As a minimum, members shall comply with Medical Board of Nevada requirements, or comparable requirements of other applicable licensing agencies;

(i) Work cooperatively, with members, nurses, hospital administration, and others so as not to adversely affect patient care;

(j) Accept responsibility for emergency care and for support of the Emergency Room, including consultation and/or admission as may be necessary. Availability and assignment shall be in accordance with policies formulated by the Medical Executive Committee. Such policies may call for voluntary participation in Emergency Room call responsibilities; the Medical Executive Committee may require mandatory participation if voluntary policies fail to assure the necessary coverage. Medical Staff members who are at least 65 years of age may request removal from emergency call and other rotational obligations. The Medical Executive Committee shall recommend to the Board whether to grant these requests based on the needs of patients, the Hospital's legal obligations under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), and the effect on others who serve on the call roster for that specialty. The Medical Executive Committee recommendation shall be subject to final approval by the Board; and

(k) Continuously meet the qualifications for membership as set forth in these Bylaws. (It is understood that a member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws whenever the Medical Executive Committee has good cause to question whether the member continues to meet such requirement.)

2.09 WAIVER OF QUALIFICATIONS

Insofar as is consistent with applicable laws, any qualification may be waived by the Board if recommended by the Medical Executive Committee upon determination that such waiver will serve the best interests of the patients and of the Hospital. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances and that his or her qualifications are equivalent to or exceed the criterion in question. No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a denial of appointment or clinical privileges.

ARTICLE 3: CATEGORIES OF THE MEDICAL STAFF

3.01 CATEGORIES

The Medical Staff shall be divided into Active, Provisional, Courtesy, Consulting, and Allied Health categories. Except for the Consulting Staff and Allied Health Staff appointments, all initial appointments to the Medical Staff shall be to the Provisional category.

3.02 ACTIVE STAFF

The Active Staff shall be composed of physicians, dentists and podiatrists who utilize the Hospital on a regular basis by having at least 10 patient encounters per year and who have completed their Provisional Staff terms satisfactorily. Active Staff members may vote on all matters presented at general and special Staff meetings, are expected to attend meetings as required under Section 11.04, and may hold office if they meet the requirements in section 9.01-2 and serve on committees, except that limited license members shall only have the right to hold office or vote on matters within the scope of their licensure. In the event of a dispute over a limited license member's right to vote or hold office, the issue shall be determined by the chairperson of the meeting, subject to final decision by the Medical Executive Committee.

3.03 PROVISIONAL STAFF

(a) The Provisional Staff shall consist of physicians, dentists and podiatrists who are newly appointed to the medical Staff and who intend to admit or treat more than 10 patients per year. Except for Consulting Staff appointments or as otherwise determined by the Governing Body, all initial appointments to the Staff shall be to the Provisional category. Provisional members who will, after successful completion of the provisional period, be placed on the Active Staff are expected to attend Staff meetings as required under Section 11.04, and they may serve on Staff committees but may not vote at any general or special meeting of the Staff. A Provisional member may not serve as a general Staff officer or a committee chairperson.

(b) Each Provisional member shall be proctored in accordance with proctoring requirements established by the Medical Executive Committee, in accordance with the provisions of Section 5.08. A member remains in Provisional status until he/she meets all the qualifications and has successfully completed his/her proctoring program. Provisional appointments are for not less than 6 months, and a member may serve no more than two consecutive 6 month

terms as a Provisional Staff member, unless a special exception is approved by the Medical Executive Committee for an additional 6 month period. The Chief of Staff shall certify satisfactory completion of the Provisional period to the Medical Executive Committee and the Chief Executive Officer.

3.04 COURTESY STAFF

The Courtesy Staff shall consist of physicians, dentists and podiatrists who admit or treat not more than 10 patients per year in the Hospital, and who are members of the medical staff of another accredited hospital, where such staff member is subject to a patient care audit program and other quality maintenance activities similar to those required by this Hospital. A Courtesy Staff member may attend meetings of the Staff and any Staff or Hospital education programs. Courtesy members are not eligible to vote or to hold office in the Medical Staff organization, or the committees.

3.05 CONSULTING STAFF

The Consulting Staff shall consist of physicians, dentists and podiatrists who possess ability and knowledge so as to constitute an important adjunct in the care of difficult cases. Consulting Staff members may not admit patients to the Hospital. A Consulting Staff member may attend meetings of the Staff, and any Staff or Hospital education programs. Consulting Staff members are not eligible to vote or hold office in the Medical Staff organization, or the committees.

3.06 ALLIED HEALTH STAFF

The Allied Health Staff shall be composed of Allied Health Professionals who have been granted clinical privileges by the Board. Members of the Allied Health Staff:

(1) may attend Medical Staff meetings;

(2) may not vote at vote Medical Staff meetings;

(3) may be appointed to Medical Staff committees as voting or non-voting members; and

(4) may not serve as a Medical Staff officer.

ARTICLE 4: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

4.01 APPLICATION FOR INITIAL APPOINTMENT

Membership on the Medical Staff and/or clinical privileges shall be extended to, and may be maintained by only those professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. The first step to begin the application process is payment of $200 to : HGH Medical Staff.

4.01-1 NATIONAL PRACTITIONER DATA BANK

In accordance with Title IV of Public Law 99-660, an authorized representative of the Hospital is

required to query the National Practitioner Data Bank on each applicable practitioner who applies for privileges (permanent or locum tenens). The Hospital representative is also required to query the Data Bank every two years when practitioners apply for reappointment of privileges. The Hospital representative will query/report to the Data Bank as outlined in the National Practitioner Data Bank Guidebook.

4.01-2 COMPLETION OF APPLICATION

All applicants for Medical Staff membership must complete, sign, and submit to the Hospital Administrator, or his/her designee, the Hospital's Application for Medical Staff Membership and Clinical Privileges, established by the Medical Executive Committee and approved by the Governing Body.

4.01-3 CONTENT OF FORM

The application form shall be developed by the Medical Executive Committee, and shall be subject to approval by the Governing Body. The application shall include a statement of agreement to abide by the Medical Staff Bylaws and Rules and Regulations, and such lawful and reasonable requirements imposed by the Hospital. The application shall also include statements regarding the applicant's involvement in any professional liability actions, previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration, voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges while under investigation or disciplinary action at another, hospital or health facility, and information detailing any prior or pending government agency or third party payor investigation, proceeding, or litigation challenging or sanctioning the practitioner's patient admission, treatment, discharge, charging, collection, or utilization practices, including but not limited to Medicare or Medicaid fraud and abuse proceedings or convictions.

4.01-4 EFFECT OF APPLICATION

By applying for or by accepting appointment or reappointment to the Medical Staff, the applicant:

(a) Signifies his/her willingness to appear for interviews in regard to his/her application for appointment;

(b) Authorizes Medical Staff and Hospital representatives to consult with other hospitals, persons or entities who have been associated with him/her and/or who may have information bearing on his/her competence and qualifications;

(c) Consents to the inspection, by Hospital representatives, of all records and documents that may be material to an evaluation of his/her professional qualifications and ability to carry out the clinical privileges he/she requests as well as of his/her professional ethical qualifications for Staff membership, regardless of who is in possession of these records;

(d) Releases from liability to the fullest extent of the law the Medical Staff and the Hospital and their representatives for their acts performed in connection with evaluating the applicant;

(e) Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives concerning the applicant's ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Staff appointment and clinical privileges;

(f) Authorizes and consents to Hospital representatives providing other hospitals, professional societies, licensing boards, and other organizations concerned with provider performance and the quality of patient care with relevant information the Hospital may have concerning him/her, and releases the Hospital and Hospital representatives from liability for so doing;

(g) Consents to undergo and to release the results of a medical, psychiatric, or psychological examination by a practitioner acceptable to the Medical Executive Committee, at the applicant's expense, if the Medical Executive Committee has any concerns about the individual's ability to perform the privileges requested or the responsibilities of appointment; and

(h) Signifies his/her willingness to abide by all the conditions of membership, as stated on the application form, the reapplication form, and in these Bylaws.

4.01-5 PROCESSING THE APPLICATION

(a) Applicant's Burden: The applicant shall have the burden of producing adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability, and, upon request of the Medical Executive Committee or of the Governing Body, physical and mental health status (as evidenced by the results of a medical, psychiatric, or psychological examination conducted by a practitioner acceptable to the Medical Executive Committee), and of resolving any doubts about these or any of the other qualifications specified in these Bylaws.

(b) Verification of Information: The applicant shall fill out and deliver an application form to the Administrator, who shall, within 30 days, seek to verify the information submitted with primary sources. The application will be deemed complete when the $200 application fee has been received and all necessary verifications have been obtained, including current license, DEA certificate if appropriate, verification of all practice from professional school through the present, current malpractice liability insurance and reference letters. The Administrator shall then transmit the application and all supporting materials to the Medical Executive Committee.

(c) Incomplete Application.

(1) If the Administrator is unable to verify the information, or if all necessary references have not been received, or if the application is otherwise significantly incomplete, the Administrator may delay further processing of the application, or may begin processing the application based only on the available information with an indication that further information may be considered upon receipt. An application that had been deemed complete will become incomplete if the need arises for new,

additional, or clarifying information at any time.

(2) If the processing of the application is delayed for more than 60 days and if the missing information is reasonably deemed significant to a fair determination of the applicant's qualifications, the affected practitioner shall be so informed. He/She shall then be given the opportunity to withdraw his/her application, or to provide the information necessary to complete the continued processing of his/her application, but shall be informed that such an election shall not relieve him/her from the provisions of Section 4.01-4(a) of these Bylaws. If the applicant does not respond within 30 days, he/she shall be deemed to have voluntarily withdrawn his/her application. Such an applicant's application may, thereafter, be reconsidered only if the Medical Executive Committee approves the extension, all requested information is submitted, and all other information has been updated.

(d) Medical Executive Committee Action: At its next regular meeting, the Medical Executive Committee shall consider all relevant information available to it. The Medical Executive Committee shall then forward to the Governing Body a written report and recommendations, as well as any minority report, as to Staff appointment, clinical privileges to be granted, and any special conditions to be attached to the appointment.

(1) Favorable Recommendation: When the recommendation is favorable, the Chief Executive Officer shall promptly forward it to the Governing Body together with the application form and its accompanying information and the reports (including any minority reports) and recommendations.

(2) Adverse Recommendation: When the recommendation is adverse the Chief Executive officer shall immediately inform the practitioner by special notice, and he/she shall be entitled to the procedural rights as provided in Article 7. The Governing Body shall be informed of, but shall not take action on, the pending recommendation until the applicant has exhausted or waived his/her procedural rights.

For the purposes of this section, an "adverse recommendation" by the Medical Executive Committee is as defined in Sections 7.04-1 and 7.04-2 of these Bylaws. A "minority report" is a dissenting opinion on the recommendation together with the reasons for the dissent.

(e) Deferral: The Medical Executive Committee may defer its recommendation in order to obtain or clarify information, or in other special circumstances. A deferral must be followed up within 60 days of receipt of information with a subsequent recommendation for appointment and privileges, or for rejection for Staff membership.

(f) Governing Body Action: On favorable Medical Executive Committee recommendation: The Governing Body shall, within 60 days, adopt or reject a favorable recommendation of the Medical Executive Committee, or shall refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for the referral and setting a time limit within which the Medical Executive Committee shall respond. If the Governing Body's action is adverse to the applicant, the Chief Executive officer shall promptly

inform the applicant by special notice, and he/she shall be entitled to the procedural rights as provided in Article 7. Whenever the Governing body's decision differs with the Medical Executive Committee recommendations then the rationale for their decision will be returned in writing with their recommendation.

(g) Notice of Final Decision: The Chief Executive Officer shall give notice of the Board's final decision to the Medical Executive Committee and (by special notice, if adverse) to the applicant. A decision and notice to appoint shall include: (i) the Staff category to which the applicant is appointed; (ii) the clinical privileges he/she may exercise; and (iii) any special conditions attached to the appointment.

(h) Time Periods for Processing: Applications for Staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in these Bylaws, and summarized in this Section 4.01-4. The Medical Executive Committee shall review the application and make its recommendation to the Governing Body within 30 days after receiving the completed application. The Governing Body shall then take action on the application at its next regular meeting. These time periods are provided to assist in the processing of the application and not to create rights for applicants to have their applications processed within these specific periods.

4.01-6 TELEMEDICINE PRIVILEGES

(a) A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff.

(b) Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as determined by the CEO in consultation with the Chief of Staff:

(1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in these Bylaws, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.

(2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) confirmation that the practitioner is licensed in Nevada;

(ii) a current list of privileges granted to the practitioner;

(iii) information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;

(iv) a signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

(v) a signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up to date; and

(vi) any other attestations or information required by the agreement or requested by the Hospital.

This information shall be provided to the MEC for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in these Bylaws.

(c) Telemedicine privileges, if granted, shall be for a period of not more than two years.

(d) Individuals granted telemedicine privileges shall be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

(e) Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

4.02 DURATION OF APPOINTMENT

The Medical Executive Committee shall develop policies and procedures (which shall become effective upon approval by the Governing Body) to implement the following:

(a) All new Staff members shall be appointed to the Provisional Staff and subjected to a period of formal observation and review (except for those appointed to the Consulting Staff or Allied Health Staff). Provisional appointments are for not less than 6 months, and a member may serve no more than two consecutive 6 month terms as a Provisional Staff member, unless a special exception is approved by the Medical Executive Committee for an additional 6 month period, not to exceed 18 months.

(b) Reappointments to any Staff category shall be for a period of two years. Change in Staff category may be requested at any time during the reappointment period after requirements of Provisional status are met.

(c) If an application for reappointment has been submitted in a timely manner, but has not been fully processed by the expiration date of the appointment, the Chief Executive Officer, upon the recommendation of the Chief of Staff, may grant the individual temporary clinical privileges until such time as Board can act on the application, provided there is an important patient care need that mandates an immediate authorization to practice, including but not

limited to an inability to meet on-call coverage requirements or denying the community access to needed medical services. The temporary privileges will be for a period up to 120 days and shall not create a right for the member to be automatically reappointed.

(d) Recommendations for appointment or reappointment or the granting of initial or renewed privileges, may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Unless the conditions would constitute an adverse recommendation under Article 7 of these Bylaws, the imposition of such conditions does not entitle an individual to the procedural rights set forth in Article 7.

(e) Appointment, reappointment or the granting of clinical privileges may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for a period of less than two years does not entitle an individual to the procedural rights set forth in Article 7.

4.03 REAPPOINTMENT PROCESS

4.03-1 INFORMATION FORM FOR REAPPOINTMENT

At least 120 days prior to the expiration date of each Staff member's term of appointment, the Administrator shall provide the member with a reappointment form. Completed reappointment forms shall be returned to the Administrator within 30 days or a registered reminder will be sent. Failure, without good cause, to return the form and the $200 reapplication fee within 90 days shall be deemed a voluntary resignation effective at the expiration of the member's current term.

4.03-2 CONTENT OF REAPPOINTMENT FORM

The reappointment form shall be developed by the Medical Executive Committee and shall be subject to approval by the Board. The reappointment form shall seek at least the following: information necessary to update the Medical Staff file on the Staff member's health care related activities other than as a member of this Staff; a statement of agreement to abide by Hospital and Medical Staff Bylaws, Rules and Regulations, a statement detailing the amounts of malpractice insurance carried; and a renewed request for clinical privileges. In addition to completing the information requested on the reappointment form, the Staff member shall be responsible to provide any physical or mental health evaluations requested. The application for reappointment shall also include statements regarding the applicant's involvement in any professional liability actions; previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration in this or any other state; voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or health facility; and information detailing any prior (within the preceding five years) or pending government agency or third party payor investigation, proceeding, or litigation challenging or sanctioning the practitioner's patient admission, treatment, discharge, charging, collection, or utilization practices, including but not limited to Medicare or Medicaid fraud and abuse proceedings or convictions.

4.03-3 CONTINUING COMPLIANCE WITH REQUIREMENTS

By applying for reappointment and by accepting reappointment to the Medical Staff, the Staff member signifies his/her continuing acknowledgment and acceptance of the provisions of Section 4.01-4. Continued membership and exercise of clinical privileges shall require at least the following:

(a) Documentation of continuing satisfaction of the General Qualifications set forth in Section 2.02; and insofar as clinical privileges are concerned, with the requirements applicable from time to time to the exercise of such privileges;

(b) Satisfactory results in Medical Staff quality assessment reviews, or satisfactory correction of any significant problems identified through such reviews;

(c) Satisfaction of the meeting attendance requirements of the Medical Staff;

(d) Documentation of "reporting endorsements" (tail coverage) or "prior acts coverage" (nose coverage) when changing insurance companies; and

(e) Written notification to the Chief of Staff of any subsequently occurring changes in the information submitted in the application or reappointment form.

4.03-4 PROCESSING THE APPLICATION

The reappointment application shall be processed in substantially the same manner and subject to the same conditions described in Section 4.01-4 including a requirement of a $200 payment to the HGH Medical Staff. Personal interviews may, but need not be, conducted. For purposes of reappointment, the terms "applicant" and "appointment" as used in that section shall be read, respectively, as "Staff member" and "reappointment".

4.04 REQUESTS FOR MODIFICATION OF APPOINTMENT

(a) A Staff member may, at any time, request modification of his/her clinical privileges, and a non Provisional Staff member may request modification of his/her staff category by submitting a written application to the Chief of Staff on the prescribed form. Such application shall be processed in substantially the same manner as provided in Section 4.03 for reappointment.

(b) The Medical Executive Committee may recommend to the Governing Body that a change in Staff category of a current Staff member or the granting of additional privileges to a current Staff member be made provisional in accordance with procedures similar to those outlined in Section 3.06 for initial appointments.

4.05 REAPPLICATION AFTER ADVERSE DECISION

(a) The following persons shall not be eligible to reapply for Medical Staff membership and/or clinical privileges affected by the previous action for a period of at least one year from the date the adverse decision became final, the date the application or request was withdrawn, or the date the former Medical Staff member's resignation became effective, whichever is applicable:

(1) An applicant who - (i) has received a final adverse decision regarding appointment or (ii) withdrew his or her application or request for membership or privileges following an adverse recommendation by the Medical Executive Committee or Governing Body;

(2) A former Medical Staff member who has - (i) received a final adverse decision resulting in termination of Medical Staff membership and clinical privileges or (ii) resigned from the Medical Staff following the issuance of a Medical Staff or Governing Body recommendation adverse to the member's Medical Staff membership or clinical privileges; or

(3) A Medical Staff member who has received a final adverse decision resulting in - (i) termination or restriction of his/her clinical privileges or (ii) denial of his/her request for additional clinical privileges.

(b) A decision shall be considered to be adverse, for medical disciplinary reasons, only if it is based on the type of occurrences which might give rise to corrective action and not if it is based upon reasons that do not pertain to medical or ethical conduct. Actions which are not considered adverse include actions based on a failure to maintain a practice in the area (which can be cured by a move), or to maintain professional liability insurance (which can be cured by securing such insurance). Further, for the purpose of this section, an adverse decision shall be considered final at the time of completion of: (i) all hearings, appellate review, and other quasi-judicial proceedings conducted by the Hospital bearing on the decision, and (ii) all judicial proceedings bearing upon the decision which are filed and served within one year after the completion of the Hospital proceedings described in above.

(c) After the one year period, the former applicant, former Medical Staff member, or Medical Staff member may submit an application for Medical Staff membership and/or clinical privileges, which shall be processed as an initial application. The former applicant, former Medical Staff member, or Medical Staff member shall also furnish evidence that the basis for the earlier adverse recommendation or action no longer exists and/or of reasonable rehabilitation in those areas which formed the basis for the previous adverse recommendation or action, whichever is applicable. In addition, such applications shall not be processed unless the applicant or member submits satisfactory evidence to the Medical Executive Committee that he/she has complied with all of the specific requirements any such adverse decision may have included, such as completion of training or proctoring conditions. The Medical Executive Committee decision as to whether satisfactory evidence has been

submitted shall be final, subject only to further review by the Governing Body within 45 days after the Medical Executive Committee decision was rendered.

4.06 CONFIDENTIALITY; IMPARTIALITY

To maintain confidentiality, and to ensure the unbiased performance of appointment and reappointment functions, Staff members participating in the credentialing process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for processing applications for appointment and reappointment.

ARTICLE 5: DETERMINATION OF CLINICAL PRIVILEGES

5.01 EXERCISE OF PRIVILEGES

Except in emergency situations every practitioner providing direct clinical services at this Hospital shall be entitled to exercise only those clinical privileges or services specifically granted to him/her.

5.02 DELINEATION OF PRIVILEGES IN GENERAL

5.02-1 REQUESTS

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. Such a request for clinical privileges, or a request by staff member pursuant to Section 4.04 for a modification of privileges must be supported by documentation of training and/or experience supportive of the request.

5.02-2 CRITERIA FOR PRIVILEGES DETERMINATIONS

Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, demonstrated ability, and medical and clinical judgment. The basis for privileges determinations, in connection with periodic reappointment or otherwise, shall include any observed clinical performance and judgment, performance of a sufficient number of procedures each year to develop and maintain the practitioner's skills and knowledge, and the documented results of the patient care audit and other quality assessment activities required by the Medical Staff Bylaws and Rules and Regulations. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a practitioner exercises clinical privileges. This information shall be added to and maintained in the Medical Staff file established for each Staff member.

5.02-3 PROCEDURE

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article 4 and subject to the restrictions regarding proctoring outlined in Section 5.08.

5.03 CONSULTATIONS

Consultations may be required at the discretion of the Chief of Staff. In addition, the Medical Executive Committee may identify instances where consultation will be required as a matter of course.

5.04 CREDENTIALING OF ALLIED HEALTH PROFESSIONALS

5.04-1 CATEGORIES

The Governing Body shall determine, based upon recommendation of the Medical Executive Committee and such other information as it has before it, those categories of Allied Health Professionals that shall be eligible to exercise clinical privileges in the Hospital. Such Allied Health Professionals shall be subject to the supervision requirements developed by the Medical Executive Committee and the Governing Body.

5.04-2 CREDENTIALING PROCEDURE

(a) An Allied Health Professional must satisfy the following threshold criteria to be eligible to apply for clinical privileges:

(1) have a current, unrestricted license, certification, or registration to practice in Nevada that is not subject to probation and have never had a license, certification, or registration to practice revoked, denied, or suspended by any state licensing agency;

(2) where applicable to their practice, have a current, unrestricted DEA registration;

(3) have current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Board;

(b) Except as provided in Section 5.04-5, applications for Allied Health Professional privileges will be processed in the same manner as specified in Section 4.01.

(1) The applicant will obtain and complete an application form.

(2) The Medical Executive Committee shall make a recommendation to the Governing Body through the Chief Executive Officer.

(3) Applications shall be processed in timely fashion appropriate to the circumstances of the case.

5.04-3 FREQUENCY OF CREDENTIALS REVIEW

The Medical Executive Committee shall develop policies and procedures (which shall become effective upon approval by the Governing Body) to implement the following:

(a) All new Allied Health Professionals shall be subject to a 6 month period of formal proctoring.

(b) Proctoring requirements shall be determined by the Medical Executive Committee.

(c) Upon successful completion of the proctoring period, the credentials of each Allied Health Professional practicing in the Hospital shall be reviewed at least biennially.

5.04-4 PRIVILEGES AND RESPONSIBILITIES

(a) Allied Health Professionals may exercise only those privileges specifically granted them by the Governing Body. The range of privileges for which each Allied Health Professional may apply and any special limitations or conditions to the exercise of such privileges shall be based on recommendations of the Medical Executive Committee and approved by the Governing Body.

(b) Each Allied Health Professional shall be required to comply with all applicable rules, and to participate in and cooperate with patient care audit and other quality review, evaluation, and monitoring activities required of Allied Health Professionals and in supervising initial appointees of his/her same occupation or profession or of a lesser included occupation or profession, and in discharging such other functions as may be required from time to time.

5.04-5 ADVERSE ACTIONS

Denial, revocation, or modification of an Allied Health Professional's privileges shall be the prerogative of the Medical Executive Committee and the Governing Body. The procedural rights described in these Bylaws for Medical Staff members shall not apply to Allied Health Professionals. However, prior to the Board permanently denying, revoking, or modifying privileges of an Allied Health Professional for any disciplinary reason, such Allied Health Professional shall be given notice of the proposed action and an opportunity to present written or verbal response to the Medical Executive Committee. This section shall not be deemed to afford an Allied Health Professional a right to an adversarial hearing as described in Article 7, nor shall it be deemed to limit the ability of the Chief of Staff to summarily restrict or suspend privileges whenever circumstances warrant such action for the protection of patients. The Chief Executive Officer may also summarily restrict or suspend privileges when the Medical Executive Committee and the Chief of Staff are not available despite reasonable attempts to contact them and when failure to take action may result in an imminent danger to the health of any individual.

5.05 LOSS OF SPONSOR

In the event an Allied Health Professional's required sponsor loses or resigns his/her clinical privileges or his/her legal right to sponsor and/or supervise the Allied Health Professional, then the Allied Health Professional's privileges shall be automatically rescinded. This shall not be deemed an adverse action, and shall not entitle the Allied Health Professional to the procedural rights set forth in Section 5.04-5, or in Article 7 of these Bylaws. An Allied Health Professional's privileges will not be automatically rescinded if the Allied Health Professional enters into a formal written relationship

with a new sponsor within 30 days, provided that the Allied Health Professional may not exercise clinical privileges until such sponsorship is in effect.

5.06 CONFIDENTIALITY; IMPARTIALITY

To maintain confidentiality, and to ensure the unbiased performance of privilege review functions, Staff members participating in the credentialing process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for processing applications for clinical privileges.

5.07 TEMPORARY PRIVILEGES AND LOCUM TENENS

5.07-1 CIRCUMSTANCES

Temporary Privileges may be granted by the CEO or the CEO's designee when recommended by the Chief of Staff in the following circumstances:

(a) Pendency of Application: When an applicant for initial appointment has submitted a completed application, including a request for temporary privileges, and the application is pending review by the Medical Executive Committee and Board, an appropriately licensed applicant may be granted temporary privileges for a period not to exceed 30 days and may be renewed in 30-day increments up to a total of 90 days. In order to be eligible for this type of temporary privileges, an individual must demonstrate that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he/she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility. In exercising such privileges, the applicant shall act under the supervision of the Chief of Staff or the Chief of Staff's designee, and in accordance with the conditions specified in Section 5.07-2.

(b) Locum Tenens: A practitioner applying for temporary privileges in a locum tenens capacity shall follow the same procedure required for appointments and reappointments, as specified in Article IV. After receipt of an application for locum tenens appointment, including a request for specific temporary privileges, an appropriately licensed practitioner of documented competence who is serving as a locum tenens for a member of the Medical Staff may be granted temporary privileges for a period not to exceed 30 days. Locum tenens appointments may be renewed in 30 day increments up to a total of 90 days.

(c) Care of Specific Patients: Upon receipt of a written application for specific temporary privileges, a practitioner who is not an applicant for membership may be granted temporary privileges for the care of one or more specific patients. Such privileges shall be restricted to the treatment of not more than four patients in any one year by any practitioner. Practitioners requesting permission to attend more than four patients in any one year shall be required to apply for Medical Staff membership before being granted the requested privileges.

(d) Verification of Information: The following verified information will be considered prior to the granting of any temporary privileges: current licensure, relevant training, experience, current competence, satisfaction of the insurance requirements set forth in Section 13.04, and results of a query to the National Practitioner Data Bank.

5.07-2 CONDITIONS

Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested, and only after the practitioner has satisfied the requirement of Section 13.04 regarding professional liability insurance. Special requirements of consultation and reporting may be imposed by the individual responsible for supervision of a practitioner granted temporary privileges. Before temporary privileges are granted, the practitioner must acknowledge in writing that he/she has received the Medical Staff Bylaws, Rules and Regulations, and that he/she agrees to be bound by their terms, whether or not he/she has actually read such Bylaws, Rules and Regulations.

5.07-3 TERMINATION

Temporary privileges may be terminated at any time by the Chief of Staff. Where the life or well-being of a patient is determined to be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Article 6.

5.07-4 RIGHTS OF THE PRACTITIONER

Except in cases where denial, termination or suspension of temporary privileges must be reported to the Medical Board of Nevada, a practitioner shall not be entitled to the procedural rights afforded by Article 7 because off his/her inability to obtain temporary privileges or because of any termination or suspension of temporary privileges.

5.08 PROCTORING

5.08-1 APPOINTMENT OF PROCTORS

All initial appointees to the Medical Staff and all members granted new clinical privileges may be subject to a period of proctoring as determined by the Medical Executive Committee. Proctoring shall be conducted under the auspices of the Medical Executive Committee. The duty of the proctor is not to participate in patient care, but to review and report to the committee. The Chief of Staff shall appoint proctors, and the persons appointed shall be deemed members of the Medical Executive Committee with respect to serving as a proctor.

5.08-2 GUIDELINES

The Medical Executive Committee shall develop Rules and Regulations (subject to approval by the Governing Body) to implement the following guidelines relative to proctoring:

(a) Proctoring will begin immediately, with the first case scheduled or admitted, following appointment (including locum tenens appointments) to the Staff. Proctoring may be required whenever indicated for the evaluation of professional competence or performance.

(b) Proctors shall submit written reports on appropriate evaluation forms promptly following each case evaluated.

(c) The Medical Executive Committee shall require sufficient evaluations to provide adequate basis for determining competency or defining privileges.

5.08-3 COMPLETION OF PROCTORING; CONSEQUENCES OF FAILURE TO COMPLETE PROCTORING

(a) A Provisional Staff member or applicant for additional clinical privileges shall remain subject to proctoring until he/she has furnished to the Medical Executive Committee a report signed by the Chief of Staff describing the types and numbers of cases which were proctored, and an evaluation of the member's performance stating that the member meets all of the qualifications, has discharged all of the responsibilities, and has not exceeded or abused the prerogatives of the category to which he/she was appointed.

(b) A Provisional Staff member who fails to complete the necessary number of proctored cases within the time frame established shall be deemed to have voluntarily resigned from the Medical Staff. Similarly, a Staff member in any category who is subjected to proctoring as a result of seeking additional clinical privileges must complete the necessary number of proctored cases within the time frame established, or shall be deemed to have voluntarily relinquished the particular privileges subject to proctoring. There shall be no procedural rights associated with any such relinquishment. The member may reapply for membership or clinical privileges after six months.

(c) A member who completes the necessary volume of proctored cases, but nonetheless fails to obtain the necessary certification of satisfactory completion of such cases shall be terminated (or in the case of applicants for additional privileges, such privileges shall be terminated); however, the practitioner shall be afforded the procedural rights provided in Article 7.

ARTICLE 6: CORRECTIVE ACTION

6.01 COLLEGIAL INTERVENTION

(1) These Bylaws encourage the use of progressive steps by the Medical Executive Committee or their designee, beginning with collegial and educational efforts, to address questions relating to
an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

(2) Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement, and peer review.

(3) Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of staff members and pursuing counseling, education, and related steps, such as the following:

(a) advising colleagues of all applicable policies, such as policies regarding emergency call obligations and the timely and adequate completion of medical records;

(b) proctoring, monitoring, consultation, and letters of guidance; and

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

(4) The Medical Executive Committee will determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential Medical Staff file. If documentation of collegial efforts is included in an individual's file, the individual will be notified and have an opportunity to review it and respond in writing. The response will be maintained in that individual's file along with the original documentation. Medical Staff files will be maintained in the Medical Staff Office.

(5) Collegial intervention efforts are encouraged, but are not mandatory, and will be within the discretion of the Medical Executive Committee.

(6) The Medical Executive Committee will determine whether to direct that a matter be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy, hospital staff policy). The MEC may also initiate an investigation per section 6.03.

6.02 DISRUPTIVE BEHAVIOR

6.02-1 PURPOSE

To promote patient safety and quality improvement through facilitating communication and cooperation among health care professionals by describing and prohibiting disruptive behavior involving Medical Staff members and delineating the response to be followed in all cases of allegations of disruptive behavior involving Medical Staff members. Disruptive behavior by members of the Medical Staff, or refusal of members to cooperate with the procedures described in this Policy, may result in corrective action, which shall be carried out according to these Bylaws.

6.02-2 DEFINITIONS

A. "Disruptive Behavior" means any behavior including without limitation, harassment, sexual harassment or other forms of inappropriate behavior which:

(1) jeopardize or is inconsistent with quality patient care or with the ability of others to provide quality patient care at the Hospital;

(2) is unethical;

(3) constitutes the physical or verbal abuse of patients or others involved with providing patient care at the Hospital; or

(4) demonstrates a failure to maintain a professional demeanor on the Hospital campus.

B. "Harassment" means verbal or physical abuse directed against any individual (e.g., against another Medical Staff member, house staff, Hospital employee or patient) on the basis of race, color, national origin, ancestry, religious creed, age, disability, sex, sexual orientation, gender identity or expression, or marital status, and shall not be tolerated.

C. "Member" and "Medical Staff member" is defined, for purposes of this Section 6.02, as an individual who has been granted Medical Staff membership or, although not a Medical Staff member, has been granted clinical privileges as an Allied Health Professional, temporary privileges, or disaster privileges. The term does not include medical students or residents.

D. "Sexual harassment" is defined as unwelcome sexual advances, requests for sexual favors, or verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment related decisions; or unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person's work performance or which creates an offensive, intimidating or otherwise hostile work environment.

6.02-3 POLICY

A. Behavior by Medical Staff members while on Hospital property that generates a complaint by another Medical Staff member, a member of the Hospital clinical or administrative staff, or individuals in contact with the Medical Staff member will be responded to according to these Bylaws. Behavior that indicates that the Medical Staff member suffers from a physical, mental or emotional condition may be evaluated so as to arrange referral to promote rehabilitation for the Medical Staff member. Sexual harassment, harassment and other disruptive behavior is not acceptable to the Medical Staff and will be corrected, or if correction fails or the initial conduct warrants, discipline.

B. Disruptive behavior occurs in varying degrees, which are classified here into three levels of severity. Level I behavior is the most severe violation of this policy. Any corrective action will be commensurate with the nature and severity of the disruptive behavior. Repeated instances of disruptive behavior will be considered cumulatively, and action shall be taken accordingly.

C. Classification of severity shall follow these guidelines:

Level I: Physical violence, other physical abuse which is directed at people, sexual harassment, harassment involving physical contact or possession of weapons on hospital property in violation of applicable law.

Level II: Verbal abuse such as inappropriately speaking loudly, swearing or cursing with demeaning intent, sexual harassment or harassment that does not involve physical contact; threatening, humiliating, sexual or otherwise inappropriate comments directed at a person or persons; visual abuse such as threatening, humiliating, sexual or otherwise inappropriate writing or picture(s) directed at a person or persons, or physical violence or abuse directed in anger at an inanimate object.

Level III: Verbal abuse which is directed at-large, but has been reasonably perceived by a witness to be disruptive behavior as defined above.

6.02-4 PROCEDURE

A. Complaints about a member of the Medical Staff regarding alleged disruptive behavior must be in writing, signed and directed to the Chief of Staff. A copy of all complaints shall be provided to the CEO.

B. The Chief of Staff or designee must review the complaint promptly, and provide the complainant with a written acknowledgement of the complaint and this Article of these Bylaws.

C. The Chief of Staff or designee shall make an initial determination of authenticity and severity, and act accordingly. The CEO shall be informed of the action taken by the Chief of Staff or designee with respect to every complaint.

D. In all cases, the member involved shall be provided with a copy of this Article of these Bylaws. The member involved shall also be provided a summary of the complaint approved by the Chief of Staff that does not disclose the identity of the complainant; provided, however, that the identity of the complainant may be disclosed if the Chief of Staff and Chief Executive Officer determine that doing so is essential for the review. If the complainant's identity is disclosed, the member involved should be reminded that any retaliation is a form of disruptive conduct and will be addressed as set forth in this Section.

E. At the discretion of the Chief of Staff or at the discretion of the Medical Executive Committee, the duties here assigned to the Chief of Staff can be delegated to a different officer of the Medical Staff, on a case by case basis or for the Chief of Staff's term of office. However, if a complaint involves the Chief of Staff, the matter shall be delegated to the Vice Chief of Staff.

F. The following procedures will be followed for different levels of incidents:

Level I: The Chief of Staff or designee, in consultation with the CEO or designee, shall consider whether summary suspension is warranted and interview the complainant and, if possible, any witnesses within 2 business days of receiving the complaint. The Chief of Staff, CEO and another member of the Medical Executive Committee shall interview the Medical Staff member within 48 hours. The Chief of Staff shall provide the member the opportunity to respond in writing.

Level II: The Chief of the Medical Staff shall interview the complainant and, if possible, any witnesses within two weeks of receiving the complaint. The Chief of Staff, CEO and another member of the Medical Executive Committee shall interview the Medical Staff member within two weeks. The Chief of Staff shall provide the member the opportunity to respond in writing.

Level III: The Chief of the Medical Staff shall interview the complainant and, if possible, any witnesses within 30 days of receiving the complaint. The Chief of Staff shall provide the member the opportunity to respond in writing.

G. Any response to a complaint of disruptive behavior will depend on the totality of the circumstances surrounding the incident. The Chief of Staff's response may include but is not limited to the following options:

1. determine that no disruptive behavior occurred;
2. determine that no action is warranted;
3. issue a letter of education or of warning;
4. require a written apology to the complainant;
5. recommend the member seek personal counseling or peer counsel.
6. require the member to meet with the Medical Executive Committee; or
7. initiate corrective action pursuant to these Bylaws.

6.02-5 DISRUPTIVE BEHAVIOR AGAINST A MEDICAL STAFF MEMBER

Disruptive behavior which is directed against a Medical Staff member by a Hospital employee, board member, contractor, or other member of the Hospital community shall be reported by the member to the Hospital pursuant to Hospital policy governing conduct.

6.02-6 RETALIATION AND ABUSE OF PROCESS

A. Threats or actions directed against the complainant or those who provide information in response to a complaint, by the subject of the complaint will not be tolerated under any circumstance. Retaliation or attempted retaliation by members against complainants or others will give rise to corrective action pursuant to these Bylaws.

B. Individuals who submit a complaint or complaints which they know to be false or misleading shall be subject to corrective action under the Medical Staff Bylaws or Hospital employment

policies, whichever applies to the individual. However, this subsection shall not be interpreted to mean that individuals have a duty to investigate a matter before submitting a complaint. Also, individuals who file a complaint shall not be subject to corrective action simply because the responsible individual or committee ultimately determines that the behavior in question did not meet the definition of "disruptive behavior," "harassment," or "sexual harassment," or did not otherwise violate these Bylaws or other applicable policy.

6.03 EVALUATION OF THE NEED FOR CORRECTIVE ACTION

6.03-1 CRITERIA FOR INITIATION

Any person may provide information to the Medical Staff about the conduct, performance or competence of its members. When reliable information indicates a member may have exhibited conduct within the Hospital that is reasonably likely to be:

A. detrimental to patient safety or to the delivery of quality patient care within the Hospital;

B. unethical;

C. contrary to the Medical Staff Bylaws or Rules and Regulations;

D. below applicable professional standards;

E. disruptive of Medical Staff or Hospital operations; or

F. an improper use of Hospital resources,

then a request for an investigation of such member may be submitted to the Medical Executive Committee by the Chief of Staff, any other Medical Staff member, the CEO or the Governing Board.

6.03-2 REQUESTS FOR INVESTIGATION AND CORRECTIVE ACTION

(a) When a request for an investigation is submitted to or is raised on its own initiative by the Medical Executive Committee, then the Medical Executive Committee will review the matter and determine whether to conduct an investigation and may discuss the matter with the individual. An investigation will begin only after a formal determination by the Medical Executive Committee to do so.

(b) The Medical Executive Committee will inform the individual within 1 week that an investigation has begun. Notification may be delayed if, in the Medical Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

(c) The Chief of Staff shall inform the CEO of all actions taken in connection with an investigation.

6.03-3 INVESTIGATION

A. The investigation shall be conducted promptly by an ad hoc committee appointed by the Chief of Staff, in consultation with the CEO. An ad hoc committee may include individuals not on the Medical Staff and will always have at least one physician.

B. An outside consultant or agency may be used whenever a determination is made by the Medical Executive Committee that:

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

2. the individual under review has raised questions about the objectivity of other practitioners on the Medical Staff.

C. The investigating committee may require a physical and or mental health examination of the individual by a health care professional(s) acceptable to it. The individual being investigated must execute a release allowing:

1. the investigating committee to discuss with the health care professional(s) conducting the examination the reasons for the examination; and

2. the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee.

D. Prior to completing its investigation, the practitioner against whom corrective action has been requested shall have an opportunity to interview with the investigating committee. Prior to such interview he/she shall be informed of the specific nature of the investigation, and be invited to discuss, explain or refute the matters at issue. Such interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules set forth in Article 7 shall apply.

E. Every 30 days, the ad hoc committee shall forward a written report of the investigation's progress and again at the completion together with any recommendations to the Chief of Staff.

F. Members participating in ad hoc investigations shall not participate in deliberations or voting by the Medical Executive Committee. When the practitioner being investigated is the Chief of Staff then the Vice Chief of Staff shall appoint the ad hoc committee.

G. The Chief of Staff may conduct or delegate to be conducted a chart review of patient care of a physician without prior notification of the physician. Such chart review shall not constitute an investigation. The chart review may be retrospective, prospective or both. If it indicates concern for substandard care then the physician in question will be notified and either an

investigation as described in this section will proceed or if more appropriate a referral for a "Quality Assurance/Peer Review" committee action.

6.03-4 MEDICAL EXECUTIVE COMMITTEE ACTION

Within 30 days following the Chief of Staff's receipt of the investigative report, the Medical Executive Committee shall consider the report and take action, to include, without limitation:

A. determine that no action is justified;

B. issue a letter of guidance, counsel, warning or reprimand;

C. impose a requirement for proctoring in accordance with Section 5.08, monitoring or consultation;

D. impose conditions for continued appointment;

E. recommend additional training or education;

F. recommend reduction of clinical privileges;

G. recommend suspension of clinical privileges for a term;

H. recommend revocation of appointment and or clinical privileges; or

I. make any other recommendation that it deems necessary or appropriate.

6.03-5 PROCEDURAL RIGHTS

A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing pursuant to Article 7 will be forwarded to the CEO who will promptly inform the individual by special notice. The CEO will hold the recommendation until after the individual has completed or waived a hearing and appeal. If the individual has not requested a hearing or appeal in writing to the CEO or Chief of Staff within 30 days then a hearing or appeal is waived.

6.03-6 GOVERNING BODY INITIATION OF ACTION

If the Medical Executive Committee fails to initiate an investigation in response to a direction from the Governing Body then the Governing Body shall have the authority to initiate an independent investigation by an outside agency of such practitioner. Such action shall only be taken after written notice to the Medical Executive Committee. If the outside agency makes a recommendation that would give rise to the procedural rights described in Article 7, the individual under review is entitled to exercise those procedural rights.

6.04 SUMMARY SUSPENSION

6.04-1 CRITERIA AND INITIATION

A. Whenever a practitioner's conduct is such that a failure to take action may result in an imminent danger to the health of any individual, he/she may be summarily suspended by the Medical Executive Committee or by any of the persons authorized below. The Medical Executive Committee hereby authorizes the Chief of Staff, or when not available the Vice Chief of Staff, to summarily suspend or restrict the Medical Staff membership status or the clinical privileges of such practitioner. The Chief Executive Officer, or when not available, the Governing Body, may summarily suspend or restrict the clinical privileges of a practitioner when acting upon the recommendation of a two Active Medical Staff members when no other person authorized by the Medical Staff is available, provided the Governing Body or Chief Executive officer has made reasonable attempts to contact the persons so authorized.

B. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible therefor shall promptly give written notice of the suspension to the practitioner, Governing Body, Medical Executive Committee and Chief Executive Officer. The individual in question shall be provided with a brief written description of the reasons for the summary suspension, including the names and medical records of the patients involved (if any) within three days of the imposition of the suspension.

C. The summary restriction or suspension may be limited in duration in order to permit an investigation to be conducted. Unless otherwise indicated by the terms of the summary restriction or suspension, the practitioner's patients shall be promptly assigned to another practitioner by the Chief of Staff, considering, where feasible, the wishes of the patient in the choice of a substitute practitioner.

6.04-2 MEDICAL EXECUTIVE COMMITTEE ACTION

A. As soon as possible, but no later than 14 days after such summary suspension, a meeting of the Medical Executive Committee shall be convened to review the action taken; provided, however, that if the suspension was effected by the Governing Body or Chief Executive Officer, the Medical Executive Committee must meet within five working days, excluding weekends and holidays. Failure of the Medical Executive Committee to ratify the suspension within this time frame shall result in automatic termination of the suspension and reinstatement of the practitioner.

B. The individual may be given an opportunity to meet with the Medical Executive Committee. The individual may propose ways other than the summary suspension or restriction to protect patients, employees and or the orderly operation of the Hospital, depending on the circumstances.

C. After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Medical Executive Committee will determine whether there is sufficient information to warrant a final recommendation or whether it is necessary to commence an investigation. The Medical Executive Committee will also determine whether the summary suspension or restriction should be continued, modified or terminated pending the completion of the investigation an hearing if applicable.

6.04-3 PROCEDURAL RIGHTS

A. Unless the Medical Executive Committee recommends immediate termination of the suspension or restriction and cessation of all further corrective action (or a suspension imposed by the Governing Body is terminated through lack of Medical Executive Committee ratification within the time frame specified in Section 6.04-2), the practitioner shall be entitled to the procedural rights as provided in Article 7.The terms of the summary suspension or restriction as sustained or as modified by the Medical Executive Committee shall remain in effect pending satisfaction of any conditions of reinstatement or a final decision by the Governing Body. There shall be no procedural rights associated with any suspension of 14 days or less that is rescinded or not ratified by the Medical Executive Committee.

B. The procedural rights described in this section are limited to addressing whether the decision to impose the summary suspension was appropriate, given the information reasonably available at the time. If the Medical Executive Committee commences an investigation while the summary suspension is in effect, the Medical Executive Committee shall continue its investigation regardless of the outcome of any hearing regarding the decision to impose a summary suspension. If, following the Medical Executive Committee's investigation, it recommends action that would entitle the practitioner to the procedural rights set forth in Article 7, the practitioner may once again invoke those procedural rights.

6.05 AUTOMATIC SUSPENSION AND TERMINATION

6.05-1 LICENSE

A practitioner whose Nevada license to practice is revoked or suspended shall immediately and automatically be suspended from practicing in the Hospital. In addition, whenever restrictions have been placed on a practitioner's license, corresponding restrictions shall automatically be placed on the practitioner's privileges in the Hospital. In the case of restrictions of licensure, or at the time a practitioner seeks reinstatement following suspension or revocation (and reinstatement) of a license, the Medical Executive Committee shall convene to review and consider the matter. The Medical Executive Committee may then take such further corrective action as is appropriate to the facts disclosed in the investigation.

6.05-2 CONTROLLED DRUG NUMBER

A practitioner whose permit to prescribe or administer narcotics and dangerous drugs is revoked or suspended shall immediately and automatically be divested of his/her right to prescribe medications

covered by such permit. In addition, whenever restrictions have been placed on a practitioner's permit, corresponding restrictions shall automatically be placed on the member's prescribing privileges in the Hospital. The Medical Executive Committee shall convene to review and consider their recommendation. The Medical Executive Committee may then take such further corrective action as is appropriate to the facts disclosed in the investigation.

6.05-3 MEDICAL RECORDS

After warning of delinquency, an automatic suspension from Medical Staff membership shall be imposed for failure to complete medical records as specified in these Medical Staff Bylaws or Rules and Regulations. Such suspension shall apply to the staff member's right to admit, treat, or provide services to new patients in the Hospital, but shall not affect his/her right to continue to care for a patient already admitted by or being treated by the affected staff member. The suspension shall be effective until the medical records are completed.

6.05-4 LIABILITY INSURANCE

Automatic suspensions from Medical Staff membership shall be imposed for failure to maintain professional liability in accordance with Section 13.04. In addition, failure to maintain professional liability insurance for certain procedures shall result in automatic suspension of clinical privileges to perform those specific procedures. The suspension shall be effective until appropriate coverage is reinstated.

6.05-5 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A. Whenever there is a concern regarding the clinical practice or professional conduct involving any individual, the Chief of Staff, Medical Executive Committee may require the individual to attend a special conference with Medical Staff leaders and or with a standing or ad hoc committee of the Medical Staff.

B. The notice to the individual regarding this conference will be given by special notice at least three days prior to the conference and will inform the individual that attendance at the conference is mandatory.

C. Failure of the individual to attend the conference will be reported to the Medical Executive Committee. Unless excused by the Medical Executive Committee upon a showing of good cause, such failure will result in automatic suspension of all or such portion of the individual's clinical privileges as the Medical Executive Committee may direct. Such automatic suspension will remain in effect until the matter is resolved.

6.05-6 FAILURE TO COMPLY WITH GOVERNMENT AND OTHER THIRD PARTY PAYOR REQUIREMENTS

The Medical Executive Committee and CEO shall each be empowered to determine that certain specific rules and requirements of third party payors, government agencies, and professional review organizations are of a nature that compliance with such requirements by Medical Staff members and Allied Health Professionals is essential to Hospital and/or Medical Staff operations and that

compliance with such requirements can be objectively determined. Thereafter, upon general notice to the Medical Staff or specific notice to the affected practitioner, a practitioner may be automatically suspended for failure to comply with such requirements. The suspension shall be effective until he/she complies with such requirements.

6.05-7 FAILURE TO SATISFY THE THRESHOLD ELIGIBILITY CRITERIA, EXCLUSION AND CRIMINAL ACTIVITY

A. An individual's clinical privileges will be automatically suspended if the individual fails to satisfy any of the threshold eligibility criteria set forth in Section 2.02 of these Bylaws. Individuals must notify the Chief of Staff and the CEO immediately of any action or event that causes them to not satisfy a threshold eligibility criterion.

B. Without limiting the generality of subsection (A) of this section, an individual's clinical privileges will be automatically suspended if any of the following occur:

(1) Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's license.

(2) Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's DEA or state controlled substance authorization.

(3) Termination or lapse of an individual's professional liability insurance coverage per 2.02(a)(5) or other action causing the coverage to fall below the minimum required by the Hospital, or the coverage ceases to be in effect, in whole or in part.

(4) Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) Indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor which involves (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another.

6.05-8 PROCEDURAL RIGHTS ASSOCIATED WITH AUTOMATIC ACTIONS

A. An individual whose clinical privileges have been automatically suspended pursuant to this Section and who desires reinstatement must request reinstatement within 90 days of the automatic suspension. The Medical Executive Committee will review the request and submit a recommendation to the Board. If the request for reinstatement would require a waiver of a threshold eligibility criterion, the Medical Executive Committee will consider the factors set forth in Section 2.02 of these Bylaws in its recommendation.

B. Automatic suspension of clinical privileges will take effect immediately upon notice to the Hospital and continue until the matter is resolved, if applicable. If an individual engages in any patient contact at the Hospital after the occurrence of an event that results in automatic

suspension without notifying the Hospital of that event, then the individual will be deemed to have permanently relinquished his or her clinical privileges and appointment.

C. Whenever the automatic suspension or termination is required to be reported to the Medical Board of Nevada the practitioner shall be entitled to a hearing pursuant to Article 7.

D. In all other cases, anyone whose membership has been automatically suspended or terminated shall be entitled at his/her request to meet with the Medical Executive Committee to review the action. The review must be requested within seven days after notification of the action, will be conducted within 30 days of such notification and shall be limited to whether or not the conditions described in these sections had in fact occurred. There shall be a right to only one Medical Executive Committee review of the reasons for suspension and termination; if there is a review conducted after a suspension there shall be no right of additional review in the event a suspended practitioner is later terminated pursuant to this Section. The formal hearing procedures described in Article 7 shall not apply and the decision of the Medical Executive Committee shall then become and remain effective pending the final decision of the Governing Board.

E. Failure to resolve the underlying matter leading to the automatic relinquishment of an individual's clinical privileges within 90 days of the date of relinquishment will result in automatic resignation from the Medical Staff.

6.06 LEAVES OF ABSENCE

(A) A Medical Staff member may request a leave of absence by submitting a written request to the Medical Executive Committee (MEC). The request must state the beginning and ending dates of the leave, which will not exceed one year, and the reasons for the leave.

(B) Members of the Medical Staff must report to the MEC any time they are away from medical staff and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the MEC may trigger an automatic medical leave of absence.

(C) The MEC will determine whether a request for a leave of absence will be granted and will notify the member and the CEO of its decision. In determining whether to grant a request. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

(D) During the leave of absence, the individual will not exercise any clinical privileges. In addition, the individual will be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

(E) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement will then be reviewed by the MEC. If there is a favorable

recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. If, however a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual will be entitled to request a hearing and appeal.

(F) If the leave of absence was for health reasons, other than pregnancy, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

(G) Absence for longer than one year will result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the MEC. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Medical Staff and the Hospital.

(H) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges will lapse at the end of the appointment period, and the individual will be required to apply for reappointment.

(I) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

ARTICLE 7: "FAIR HEARING PLAN" (INTERVIEWS, HEARINGS AND APPELLATE REVIEW)

7.01 INTERVIEWS

When the Medical Executive Committee receives or is considering initiating an adverse recommendation concerning a practitioner, the practitioner may be afforded an informal interview with the Medical Executive Committee, at the discretion of the Medical Executive Committee. The interview shall not constitute a hearing, shall be preliminary in nature, and need not be conducted according to the procedural rules applicable to hearings. If the practitioner elects an interview, the practitioner will be informed of the general nature of the circumstances and may present relevant information. A record of any such interview shall be made; however, such record need not be verbatim. Nothing in the foregoing shall limit the ability of any authorized individual or body to take summary action when warranted by the circumstances.

7.02 HEARINGS AND APPELLATE REVIEW

7.02-1 ADVERSE MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION

When any practitioner receives notice of an adverse recommendation of the Medical Executive Committee, he/she shall be entitled, upon request, to a hearing before an ad hoc hearing committee of the Medical Staff or arbitrator(s), as outlined in this Fair Hearing Plan. If the recommendation following such hearing is still adverse to the practitioner, he/she shall then be entitled, upon request,

to an appellate review by the Governing Body or a hearing officer appointed by the Governing Body before a final decision is rendered by the Governing Body.

7.02-2 EXCEPTIONS

None of the following actions will constitute grounds for a hearing, and they will take effect without hearing or appeal, provided that the individual will be entitled to submit a written explanation to be placed into his or her file:

A. issuance of a letter of guidance, counsel, admonition, warning or reprimand;

B. imposition of conditions, monitoring or a general consultation requirement (i.e., the individual must obtain a consult but need not get a prior approval for treatment);

C. denial, reduction or termination of temporary privileges;

D. automatic suspensions of appointment or privileges;

E. imposition of a requirement for additional training or continuing education that does not take the practitioner away from patient care activities for an unreasonable period of time;

F. denial of a request for leave of absence or for an extension of a leave;

G. determination that an application is incomplete; or

H. determination of ineligibility based on: (1) a failure to meet threshold eligibility criteria; (2) the existence of an exclusive contract; or (3) a lack of need or resources as identified in a strategic plan, Medical Staff Development Plan or similar document approved by the Board;

I. Further, the fair hearing procedures described in these Bylaws are intended for the resolution of factual disputes, or to challenge whether or not the provisions of these Bylaws have been followed. The Fair Hearing Plan is not intended as mechanism to challenge the substantive validity of the Medical Staff or Hospital Bylaws, Rules and Regulations or policies, and the hearing committee appointed pursuant to this Fair Hearing Plan shall not be empowered to hold quasi-legislative, notice and comment type hearings, or to make quasi-legislative determinations, or determinations as to the substantive validity of bylaws, rules, regulations, or other intra-organizational legislation. Such challenges, shall instead, be made through the mechanism described in Article 8 of these Bylaws.

7.02-3 ADVERSE GOVERNING BODY DECISION

When any practitioner receives notice of an adverse decision by the Governing Body taken either contrary to a favorable recommendation by the Medical Executive Committee or on the Board's own initiative, such practitioner shall be entitled, upon request, to a hearing by a committee comprised of Medical Staff and Governing Body members appointed by the Governing Body, or by arbitrator(s), as outlined at Section 7.05-2. If such hearing results in a tie vote or an unfavorable recommendation,

he/she shall then be entitled, upon request, to an appellate review by the Governing Body or a hearing officer appointed by the Governing Body before a final decision is rendered.

7.03 EXHAUSTION OF REMEDIES

If adverse action is taken with respect to a practitioner's Medical Staff membership or clinical privileges, regardless of whether the practitioner is an applicant or a Medical Staff member, the practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action challenging the action or procedures used to arrive at the action or asserting any claim against any participants in the decision making process. (This section shall not be deemed to limit the immunities available to such participants pursuant to these Bylaws or any applicable provision of Nevada or federal law.)

7.04 INITIATION OF HEARING

7.04-1 RECOMMENDATIONS OR ACTIONS

A. Except as otherwise provided in Section 7.02-2, the following recommendations or actions shall, if deemed adverse pursuant to Section 7.04-2 and except as otherwise provided in Section 6.03 and Section 6.05, entitle the affected practitioner to a hearing:

(1) Denial of initial Staff appointment;

(2) Denial of reappointment;

(3) Suspension of Staff membership;

(4) Revocation of Staff membership;

(5) Reduction in Staff category;

(6) Limitation of the right to admit or treat patients;

(7) Denial of requested clinical privileges;

(8) Reduction in clinical privileges;

(9) Suspension of clinical privileges;

(10) Revocation of clinical privileges;

(11) Requirement of consultation (except as imposed by department Rules and Regulations or on a specific patient basis);

(12) Mandatory concurring consultation requirement (i.e.; the consultant must approve the course of treatment in advance);

(13) Denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct; or

(14) Any other "medical disciplinary" action or recommendation that must be reported to the Medical Board of Nevada.

B. No other recommendations will entitle the individual to a hearing.

C. If the Board makes any of these recommendations without an adverse recommendation by the Medical Executive Committee, an individual will also be entitled to a hearing. For ease of use, when this Article refers to adverse recommendation of the Medical Executive Committee triggering a hearing it will also include adverse recommendations made by the Board.

7.04-2 WHEN DEEMED ADVERSE

A recommendation or action listed in Section 7.04-1 shall be deemed adverse only when it has been:

(a) Recommended by the Medical Executive Committee;

(b) Taken by the Governing Body contrary to a favorable recommendation by the Medical Executive Committee; or

(c) Taken by the Governing Body on its own initiative without benefit of a prior recommendation by the Medical Executive Committee.

7.04-3 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A practitioner against whom adverse action has been taken shall promptly be given special notice of such action. Such notice shall:

(a) Contain a Notice of Charges consisting of a statement of the practitioner's alleged acts or omissions, a list by number of the specific or representative patient records in question, and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing;

(b) Advise the practitioner of his or her right to a hearing pursuant to the provisions of the Fair Hearing Plan;

(c) Specify that the practitioner has 30 days following the date of receipt of notice within which a request for a hearing must be submitted;

(d) State that failure to request a hearing within the specified time period shall constitute a waiver of rights to a hearing and to an appellate review on the matter;

(e) State that after receipt by the Hospital of his/her request, the practitioner will be notified of the date, time and place of the hearing, and the grounds upon which the adverse action is based;

(f) Contain a copy of the Fair Hearing Plan;

(g) List the witnesses expected to testify at the hearing, to the extent known at the time; and

(h) Advise the practitioner that the action, if adopted, shall be reported when required to the Medical Board of Nevada per Title IV of Public Law 99-660.

7.04-4 REQUEST FOR HEARING

A practitioner shall have up to 30 days following the date of receipt of special notice to file a written request for a hearing. Such request shall be delivered to the Chief Executive Officer either in person or by certified or registered mail.

7.04-5 WAIVER BY FAILURE TO REQUEST A HEARING

A practitioner who fails to request a hearing within 30 days from the date of receipt of special notice waives any right to such hearing and to any appellate review. Such waiver in connection with:

(a) An adverse action by the Governing Body shall constitute acceptance of that action, which shall then become effective as the final decision of the Governing Body.

(b) An adverse recommendation by the Medical Executive Committee shall constitute acceptance of that recommendation, which shall then become and remain effective pending the final decision of the Governing Body. If the Governing Body's action on the matter is in accord with the Medical Executive Committee's final recommendation, such action shall constitute a final decision of the Governing Body. If the Governing Body proposes changing the Medical Executive Committee's recommendation, the matter shall be submitted to a Joint Conference Committee of members of the Medical Staff and Governing Body selected by the Chief of Staff and Chairperson as described in the Hospital Bylaws of the Governing Body. The Governing Body's action on the matter following receipt of the joint conference recommendation shall constitute its final decision.

The Chief Executive Officer shall promptly send the practitioner special notice informing him/her of each action taken pursuant to this Section, and shall notify the Chief of Staff of each such action.

7.05 APPOINTMENT OF HEARING COMMITTEE

7.05-1 BY MEDICAL STAFF

Except as next provided, a hearing based upon an adverse Medical Executive Committee recommendation shall be conducted by a hearing committee appointed by the Chief of Staff. It will be composed of at least three members of the Medical Staff; however, at the discretion of the Chief

of Staff, hearing committee members may be selected who are not Hospital Medical Staff members. At the discretion of the Chief of Staff and with the approval of the affected practitioner, the committee may be comprised of less than three members, or the hearing may be conducted before an arbitrator or arbitrators selected by a process mutually acceptable to the Medical Executive Committee and the practitioner. One of the appointees shall be designated as chairperson.

7.05-2 BY GOVERNING BODY

A hearing based upon an adverse action of the Governing Body shall be conducted by a hearing committee appointed by the Chief of Staff, in consultation with the Chairperson of the Governing Body and composed of at least four persons, two of whom should be Medical Staff members, or the hearing may be conducted before an arbitrator or arbitrators selected by a process mutually acceptable to the Governing Body and the practitioner. One of the appointees shall be designated as chairperson. Such committee shall be deemed a Medical Staff committee.

7.05-2 SERVICE ON HEARING COMMITTEE

In order to avoid a possible claim of prejudice by the affected practitioner, a hearing committee shall be composed of individuals who have not acted as an accuser, investigator, fact-finder, or initial decision maker in the same matter, and who shall gain no direct benefit from the outcome of the hearing. Without limiting the foregoing, economic competitors of the practitioner may not serve on the hearing committee. If feasible, the hearing committee should include an individual practicing the same specialty as the practitioner.

7.05-3 VOIR DIRE

The affected practitioner shall be notified in writing of his/ her right to question the hearing committee and the presiding officer, and to challenge the impartiality of those individuals based upon bias or conflict of interest. Any such challenge of a hearing committee member(s) must be supported by facts.

7.06 ADDITIONAL NOTICES

7.06-1 NOTICE OF TIME AND: PLACE FOR HEARING

Within 10 days after receipt by the Chief Executive Officer of the request, the Chief of Staff or the Chief Executive Officer (on behalf of the Governing Body) shall schedule a hearing. The Chief Executive Officer shall send the practitioner special notice of the time, place and date of the hearing. The hearing date shall be not less than 30 days nor more than 60 days from the date of receipt of the request.

7.06-2 SUPPLEMENTAL NOTICE OF CHARGES

The Medical Executive Committee may amend its Notice of Charges (Section 7.04-3(a); provided, however, that such amendment shall be provided to the practitioner as soon as reasonably possible under the circumstances; and, provided, further, that the practitioner shall be entitled to a

continuance if any such amendment substantially changes the scope of the hearing, or substantially affects the practitioner's ability to adequately prepare for the hearing. The hearing officer shall determine whether any such continuance is necessary.

7.07 EXCHANGE OF WITNESS LISTS; DISCOVERY; PREHEARING MOTIONS

7.07-1 WITNESS LISTS

(a) If known at the time of the Notice of Adverse Recommendation or Action (Section 7.04-3), the practitioner shall be given a list of witnesses (if any) who are expected to testify at the hearing. Within five days of receipt of a request from the Medical Executive Committee, the practitioner shall forward his/her list of anticipated witnesses. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses.

(b) The failure to have provided the name of any witness at least three days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

7.07-2 DISCOVERY RIGHTS

(a) The practitioner shall have the right to inspect and copy, at his/her expense, any documentary information relevant to the charges which the Medical Executive Committee has in its possession or under its control as soon as practical after delivery of his/her request for a hearing.

(b) The Medical Executive Committee shall have the right to inspect and copy, at its expense, any documentary information relevant to the charges which the practitioner has in his/her possession or control, as soon, as practical after receipt of the Medical Executive Committee's request.

(c) The failure by either party to provide access to this information at least 30 days before the hearing shall constitute good cause for a continuance.

(d) The right to inspect and copy by either party does not extend to confidential information referring to individually identifiable practitioners, other than the practitioner under review; nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

(e) The hearing officer shall rule on any contested requests for access to information. In making such rulings, the presiding officer may impose any safeguards for protection of the peer review process and justice requires. Moreover, in making such rulings and determining the relevancy of the requested information, the presiding officer shall, among other factors, consider the following;

(1) Whether the information sought may be introduced to support or defend the charges;

(2) The exculpatory or inculpatory nature of the information sought, if any;

(3) The burden imposed on the party in possession of the information sought, if access is granted; and

(4) Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

7.07-3 PREHEARING MOTIONS

The parties shall be entitled to file prehearing motions as deemed necessary to give full effect to rights established by these Bylaws, and to resolve such procedural matters as the hearing officer determines may properly be resolved outside the presence of the full hearing committee. Such motions shall be in writing and shall specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving party shall deliver a copy of the motion to the opposing party, who shall have five working days to submit a written response to the hearing officer, with a copy to the moving party. The hearing officer shall determine whether to allow oral argument on any such motions. The hearing officer's ruling shall be in writing and shall be provided to the parties promptly upon its rendering. All motions, responses, and rulings shall be entered into the hearing record by the hearing officer.

7.07-4 PRE-HEARING CONFERENCE

The presiding officer will require the individual or a representative (who may be counsel) for the individual and for the Medical Executive Committee to participate in a pre-hearing conference. At the pre-hearing conference, the presiding officer will resolve all procedural questions, including any objections to exhibits or witnesses. The presiding officer will establish the time to be allotted to each witness's testimony and cross examination. It is expected that the hearing will last no more than 12 hours, with each side being afforded approximately six hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of 12 hours. The presiding officer may, after considering any objections, grant extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.08 HEARING PROCEDURE

7.08-1 PERSONAL PRESENCE

The personal presence of the practitioner who requested the hearing shall be required. A practitioner who fails, without good cause, to appear and proceed, or who refuses to be called and to answer questions as a witness at such hearing, shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Section 7.04-5, above.

7.08-2 HEARING OFFICER

The hearing officer, who shall be an attorney qualified and appointed in accordance with Section 7.13-1, shall be the presiding officer. The hearing officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/She shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence, including but not limited to:

(a) Rulings on challenges to the impartiality of any of the hearing committee members or of the presiding officer himself/herself;

(b) Rulings on requests for access to information pursuant to Section 7.07-2; and

(c) Prohibiting conduct or presentation of evidence that is harassing, cumulative, excessive, irrelevant or abusive or that causes undue delay.

7.08-3 REPRESENTATION

The practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the Medical Staff in good standing or by a member of his/her local professional society. The Medical Executive Committee or the Governing Body, depending on whose recommendation or action prompted the hearing, shall appoint an individual or individuals to represent it at the hearing, to present the facts in support of its adverse recommendation or action, and to examine witnesses. Representation of either party by an attorney at law (including Medical Staff or professional society members who are also attorneys shall be governed by Section 7.13-2.

7.08-4 RIGHTS OF PARTIES

During a hearing, each of the parties shall have the right, subject to the reasonable limits set by the presiding officer:

(a) To question the hearing panel and the presiding officer, and to challenge the impartiality of any member or the presiding officer, in accordance with Sections 7.05-4 and 7.08-2;

(b) To call and examine witnesses, to the extent that they are available and willing to testify;

(c) To introduce relevant evidence;

(d) To cross-examine any witness on any matter relevant to the issues;

(e) To impeach any witness;

(f) To rebut any relevant evidence;

(g) To be provided with all of the information provided to the hearing committee; and

(h) To have a record made of the hearing, in accordance with Section 7.08-8.

In addition, the affected practitioner may be called and examined as if under cross-examination.

7.08-5 PROCEDURE AND EVIDENCE

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Subject to the provisions of Section 7.08-7(b), any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to, or within 10 days after the close of the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become a part of the hearing record. The presiding officer may order that oral evidence be taken only on oath or affirmation.

7.08-6 OFFICIAL NOTICE

In reaching a decision, the hearing committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of Nevada. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Any party shall be given the opportunity, on timely request, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority (the manner of such refutation to be determined by the hearing officer).

7.08-7 BURDEN OF PRODUCING EVIDENCE; BURDEN OF PROOF

(a) The body making the adverse action or recommendation shall have the initial obligation to present evidence in support of that action or recommendation.

(b) Thereafter, initial applicants shall bear the burden of persuading the hearing committee, by a preponderance of the evidence, of their qualifications by producing information which allowsfor adequate evaluation and resolution of reasonable doubts concerning their current qualifications for staff privileges or membership. Initial applicants shall not be permitted to introduce information not produced upon request of the peer review body during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided above for initial applicants (including Medical Staff members requesting new clinical privileges), the Medical Executive Committee shall bear the burden of persuading the hearing committee, by a preponderance of the evidence, that the action or recommendation is reasonable and warranted.

7.08-8 RECORD OF HEARING

To facilitate Governing Body and possible judicial review, a record of the hearing shall be made by a court reporter. The cost of the court reporter shall be borne by the Hospital and the cost of the transcript shall be borne by the requesting party.

7.08-9 CONTINUANCE OR POSTPONEMENT AND COMPLETION OF THE HEARING

Requests for continuance or postponement of a hearing may be granted by the hearing officer only upon a showing of good cause. The hearing shall be completed within a reasonable time unless the hearing officer issues a written decision finding that the practitioner failed to comply with requests to produce documentary evidence, pursuant to Section 7.07-2, in a timely manner, or consented to the delay.

7.08-10 PRESENCE OF HEARING COMMITTEE MEMBERS AND VOTE

A majority of the hearing committee must be present throughout the hearing and deliberations. In unusual circumstances where a committee member must be absent from any part of the proceedings, he/she shall not be permitted to participate in the deliberations or the decision unless and until he/she has read the entire transcript of the portion of the hearing from which he/she was absent.

7.08-11 RECESSES AND ADJOURNMENT

The hearing committee may recess and reconvene the hearing, without additional notice, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing record shall be closed. The hearing committee shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of its deliberations, the hearing shall be declared finally adjourned.

7.09 HEARING COMMITTEE REPORT AND FURTHER ACTION

7.09-1 HEARING COMMITTEE REPORT

Within 30 days (ten working days if a summary suspension is involved) after final adjournment of the hearing, the hearing committee shall render its recommendation in writing. The recommendation shall include the hearing committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached.

7.09-2 REPORT

The hearing committee report shall be sent to the parties to the hearing together with the notice of a right to appeal and a written explanation of the procedure for appealing the decision.

7.09-3 REQUEST FOR APPEAL

Either party may request appeal of the findings and recommendations of the hearing committee, as provided at Section 7.10-2, below.

7.09-4 NO APPEAL

If an appellate review is not requested within ~~7~~ 10 days, the recommendation of the hearing committee shall be forwarded to the Governing Body for final action.

7.10 INITIATION AND PREREQUISITES OF APPELLATE REVIEW

7.10-1 REQUEST FOR APPELLATE REVIEW

A practitioner shall have 10 days following his/her receipt of a notice as provided for in Section 7.09-2 to file a written request for an appellate review. Such request shall state the grounds for the appeal (see Section 7.10-2) and shall be delivered to the Chief Executive Officer either in person or by certified or registered mail. The practitioner may also request a copy of the report and record of the hearing committee and all other material, favorable or unfavorable, if not previously forwarded, that was considered by the hearing committee or by a subsequently reviewing body in making the adverse recommendation.

7.10-2 GROUNDS FOR APPEAL

An appeal shall be based upon one or more of the following grounds:

(a) The recommendation of the hearing committee is arbitrary, capricious or not supported by substantial evidence; or

(b) The substantial failure of the hearing committee to follow the procedures outlined in the Medical Staff Bylaws.

The request for appeal shall state the specific manner in which the decision is arbitrary, capricious, or lacking in substantial basis, or in which the applicable procedures were not followed.

7.10-3 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW

A practitioner who fails to request an appellate review within the time and in the manner specified above waives any right to such review. Such waiver shall have the same force and effect as provided above for failure to request a hearing.

7.10-4 NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW

Upon receipt of a timely request for appellate review, the Chief Executive Officer shall deliver the request to the Governing Body. As soon as practical, the Governing Body shall schedule an appellate review which shall be held not less than 15 days nor more than 30 days from the date of receipt of the

request; however, an appellate review for a practitioner who is under a suspension then in effect shall be held as soon as the arrangements may reasonably be made, but not later than 30 days from the date of receipt of the request. At least 15 days prior to the appellate review, the Chief Executive Officer shall send the practitioner special notice of the time, place and date of the review. The time for the appellate review may be extended by the appellate review body for good cause and if the request for extension is made as soon as is reasonably practical.

7.10-5 APPELLATE REVIEW BODY

The Governing Body shall determine whether an appeal shall be conducted by:

(a) The Governing Body as a whole, with or without the assistance of an appellate hearing officer; or

(b) An appellate hearing officer only.

Whenever members of the Governing Body have had prior involvement, such as initiating, investigating, or reporting on matters at issue in the appeal, such member(s) shall be excluded from serving on the appellate review body, or an appellate hearing officer should be appointed pursuant to subparagraph (b), above. If an appellate hearing officer is appointed to hear the appeal by himself/herself, references throughout Sections 7.10 and 7.11 to an "appellate review body" shall be deemed to mean appellate hearing officer.

7.11 APPELLATE REVIEW PROCEDURE

7.11-1 NATURE OF PROCEEDINGS

The proceedings by the appellate review body shall be in the nature of an appellate review based upon the record of the hearing committee, that committee's report, the written statements, if any, submitted as provided below, and such other material as may be presented and accepted within the terms of this Fair Hearing Plan.

7.11-2 WRITTEN STATEMENTS

The party seeking the review may submit a written statement detailing the findings, conclusions and procedural matters with which he/she or it disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the appellate review body and the opposing party through the Chief Executive Officer at least 5 days prior to the scheduled date of the appellate review, or later if this time limit is waived by the appellate hearing officer. A written statement in reply may be submitted by the opposing party and if submitted, the Chief Executive Officer shall provide a copy to the appealing party at least three days prior to the appellate review hearing.

7.11-3 PRESIDING OFFICER

The chairperson of the appellate review body or an appellate hearing officer, if one is appointed, shall be the presiding officer. The presiding officer shall determine the order of procedure during the review, make all required rulings and maintain decorum.

7.11-4 ORAL STATEMENTS

The parties or their representatives shall have the right to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be expected to answer questions put to him/her by any member of the appellate review body.

7.11-5 CONSIDERATION OF NEW OR ADDITIONAL MATTERS

Except as otherwise provided at Section 7.10-1, new or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review level only in the discretion of the appellate hearing officer, following an explanation by the party requesting the consideration of such matter or evidence as to why it was not presented earlier.

7.11-6 POWERS

The appellate review body shall have all powers granted to the hearing committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

7.11-7 RECESSES AND ADJOURNMENT

The appellate review body may recess and reconvene the review proceedings, without additional notice, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements and upon submission of any written statements within the time frame established by the presiding officer, the appellate review record shall be closed.
The appellate review body shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

7.11-8 ACTION OF THE APPELLATE REVIEW BODY

The recommendation of the hearing committee shall be sustained, unless the appellate review body finds that the recommendation is not supported by substantial evidence, or that it is arbitrary, unreasonable, or capricious. If the recommendation is not sustained, the appellate review body may recommend that the Governing Body modify or reverse the recommendation of the hearing committee or, in its discretion, the appellate review body may refer the matter back to a hearing committee for further review and recommendation to be returned to it within 30-days (10 working days if summary suspension is involved) and in accordance with its instructions. Within 30 days (10 working days if summary suspension is involved) after receipt of a recommendation after referral, the appellate review body shall make its recommendation to the Governing Body. The appellate review body's

recommendation shall be in writing, shall include findings of fact and a conclusion articulating the connection between the evidence produced during the hearing and appeal process and the decision reached, and shall be provided to the Governing Body and the parties.

7.11-9 CONCLUSION OF APPELLATE PROCEEDINGS

The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Fair Hearing Plan have been completed or waived.

7.12 FINAL DECISION OF THE GOVERNING BODY

7.12-1 GOVERNING BODY ACTION

Within 30 days (10 working days if summary suspension is involved) after the conclusion of the appellate review, the Governing Body shall render its final decision in writing. The decision shall include the Governing Body's findings of fact and a conclusion articulating the connection between the evidence produced during the hearing and appeal process and the decision ultimately reached. The Chief Executive Officer shall send notice of the decision to the practitioner (by special notice), to the Chief of Staff, and to the Medical Executive Committee. The decision shall be immediately effective and final.

7.13 GENERAL PROVISIONS

7.13-1 HEARING OFFICER APPOINTMENT AND DUTIES

(a) The use of a hearing officer to preside at the initial hearing is mandatory. The appointment of such officer shall be by the Chief of Staff after consultation with the Chief Executive Officer. A hearing officer shall be an attorney, who must be experienced in conducting or participating in administrative hearings. He/She shall act in an impartial manner as the presiding officer of the hearing. He/She shall gain no direct financial benefit from the outcome of the hearing, shall not act as a prosecuting officer or advocate, ~~and~~ shall not be entitled to vote and shall not be affiliated with the hospital.

7.13-2 ATTORNEYS

(a) The affected practitioner shall have the right at his/her expense, to attorney representation at the hearing. If the affected practitioner elects to have attorney representation, the Medical Executive Committee may also have attorney representation. Conversely, if the practitioner elects not to be represented by an attorney in the hearing, then the Medical Executive Committee shall not be represented by an attorney in the hearing. The affected practitioner shall state in writing his/her intentions with respect to attorney representation at the time he/she files the request for a hearing. Notwithstanding the foregoing, and regardless of whether the practitioner elects to have attorney representation at the hearing, the parties shall have the right to utilize the assistance of legal counsel in connection with preparation for a hearing or an appellate review.

(b) Both parties shall have the right, at their own expense, to be represented by an attorney or any other representative designated by the party at any appellate review hearing. If the affected practitioner elects not to be represented by an attorney at this stage, the Medical Executive Committee may nonetheless elect to have attorney representation in the appellate review hearing.

7.13-3 WAIVER

If at any time after receipt of special notice of an adverse recommendation or action, a practitioner fails to make a required appearance or otherwise fails to proceed or to comply with this Fair Hearing Plan, he/she shall be deemed to have consented to such adverse recommendation or action and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the Medical Staff Bylaws or under this Fair Hearing Plan.

7.13-4 NUMBER OF REVIEWS

No practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to an adverse recommendation or action.

7.13-5 CONFIDENTIALITY; IMPARTIALITY

To maintain confidentiality, and to ensure the unbiased performance of peer review, disciplinary, and credentialing functions, Medical Staff members participating in any stages of the fair hearing process shall limit their discussion of the matters involved to the formal avenues provided in the Medical Staff Bylaws and this Fair Hearing Plan.

7.13-6 RELEASE

By requesting a hearing or appellate review under this Fair Hearing Plan, a practitioner agrees to be bound by the provisions in the Medical Staff Bylaws relating to immunity from liability.

7.13-7 GOVERNING BODY COMMITTEES

In the event the Governing Body should delegate some or all of its responsibilities described in this Article to one of its committees, the Governing Body shall nonetheless retain ultimate authority to accept, reject, modify or return for further action or hearing, the recommendations of its committee.

7.13-8 FINANCIAL EXPENSES

The Hospital will provide or pay expenses related to the general conduct of the hearing and the MEC presentation, such as the sending of notices, copying costs related to the MEC presentation, fees of presiding officers, hearing committee members, arbitrators, and any attorney representing the MEC and Hospital. The affected practitioner shall pay his or her own attorney fees, copying costs, transcript fees, and other fees related to the practitioner's presentation of his or her case.

ARTICLE 8: REVIEW OF BYLAWS, RULES AND REGULATIONS, AND POLICIES

8.01 REQUEST FOR REVIEW

A. Any Medical Staff member or applicant against whom an adverse action has been taken (as described in Sections 7.04-1 and 7.04-2) may request review leading to amendment or repeal of the underlying bylaw, rule or regulation, or policy on the basis that it is believed to be substantively irrational. Such review shall be initiated by the submission of a written request, together with the substantiating rationale for such request. A practitioner shall have 30 days following the date of receipt of special notice of such adverse action to file a written request for review of such bylaw, rule, regulation or policy. Such request shall be delivered to the Chief of Staff and CEO either in person or by certified or registered mail and shall include the substantiating rationale for such request.

B. A request for a review under this section shall result in the postponement of the obligations of the Medical Staff member and Hospital with respect to the adverse recommendation until the review requested pursuant to this section has been completed. However, a summary suspension shall not be ended solely as a result of a Medical Staff member requesting review under this section.

8.02 BYLAWS COMMITTEE REVIEW

The Medical Executive Committee shall consider request within 30 days. The Medical Executive Committee shall either:

(A) Recommend amendment of the bylaw, rule, regulation, or policy;

(B) Recommend denial of the request; or

(C) Request further information from the practitioner and/or appropriate Medical Staff committees or representatives (which information should be provided within 30 days), following receipt of which it shall recommend amendment or denial of the request for amendment.

The Medical Executive Committee failure to act within ~~30~~ 90 days shall be deemed to be a denial of the request.

8.03 MEDICAL EXECUTIVE COMMITTEE ACTION

(a) If the Medical Executive Committee recommendation is to amend the bylaw, rule, regulation, or policy substantially as requested, the amendment shall be processed as set forth in Article 14 of these Bylaws.

(b) If the Medical Executive Committee recommendation is to not amend the bylaw, rule, regulation, or policy substantially as requested, and subject to Section 8.04 below, the

affected practitioner shall be informed of such decision. Thereafter, the practitioner may, within 10 days, request that the Medical Executive Committee convene an appropriate notice and comment forum for consideration of the involved provision. Such forum shall occur within 30 days of the request and shall enable all interested Medical Staff members, adversely affected applicants, and affected Medical Staff committees or representatives, and Hospital administration an opportunity to present information relating to the involved provision.

(c) Thereafter, the Medical Executive Committee shall make its final recommendation upon the matter, considering all information presented in conjunction with the above review.

8.04 LIMITATION ON FREQUENCY OF REVIEW

Notwithstanding the above, the Medical Executive Committee shall not be compelled to reconsider any request for amendment as to any provision that has been reviewed (or that is then under review) pursuant to the above provisions, within the immediately preceding ~~two~~ 3 year period.

8.05 TIME FRAMES

Requests pursuant to this Article shall be processed as expeditiously as reasonably possible, and, except for good cause, each action or recommendation described above should occur, respectively, at the next regularly scheduled meeting of each involved committee.

ARTICLE 9: MEDICAL STAFF OFFICERS

9.01 MEDICAL STAFF OFFICERS - GENERAL PROVISIONS

9.01-1 IDENTIFICATION

(a) There shall be the following general Medical Staff Officers:

(1) Chief of Staff;

(2) Vice-chief of Staff; and

(3) Treasurer 9.01-2 QUALIFICATIONS

(a) All Medical Staff officers shall have:

(1) An understanding of the purposes and the functions of the Medical Staff organization and a demonstrated willingness to assure that patient welfare always take precedence over other concerns;

(2) An understanding of and willingness to work toward the attainment of the Hospital's policies and requirements that are lawful and reasonable; administrative ability as applicable to the respective office;

(3) An ability to work with and motivate others to achieve the objectives of the Medical Staff organization;

(4) Demonstrated clinical competence in his/her field of practice;

(5) Active Staff status (and must remain in good standing as Active Staff members while in office); ~~and~~

(6) An absence of any significant conflict of interest; and

(7) Have attended at least 50% of the Medical Staff meetings during the previous 1 year.

(b) All nominees for election or appointment to Medical Staff offices (including those nominated by petition of the Medical Staff, pursuant to Section 9.01-3(c) shall, at least 20 days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

9.01-3 METHOD OF SELECTION - GENERAL OFFICERS

A slate of candidates shall be developed by nominations from voting Medical Staff members during a general medical staff meeting at which a quorum exists as per Section 11.02-2. Candidates must meet the qualifications of office, as described in Section 9.01-2, above. The slate of candidates shall be developed at least 45 days prior to the scheduled election. At least one candidate shall be nominated for open positions for Chief of Staff, Vice Chief of Staff and Treasurer. The Medical Staff shall thereafter elect its officers. The outcome shall be determined by a majority of the voting Medical Staff. Officers shall be elected and shall take office in January.

9.01-4 TERM OF OFFICE

The term of office for officers shall be two years.

9.01-5 SUCCESSION OF OFFICERS

At the end of each term the Chief of Staff will leave office. The Vice-Chief shall, if willing, become the Chief of Staff. If the Vice-Chief is not willing, the Vice-Chief shall leave office. The Treasurer shall, if willing, become the Vice-Chief or, if not willing, shall leave office.

9.01-6 RECALL OF OFFICERS

Except as otherwise provided, recall of a general Medical Staff officer may be initiated by the Medical Executive Committee or by a majority vote of the Medical Staff members eligible to vote for officers, but recall shall require a two thirds vote of the Medical Staff members eligible to vote for general Medical Staff officers.

9.01-7 FILLING VACANCIES

Vacancies created during a term by resignation, removal, death, or disability shall be filled as follows:

(a) A vacancy in the office of Chief of Staff shall be filled by the Vice-chief.

(b) A vacancy in the office of Vice-Chief shall be filled by the Treasurer.

(c) A vacancy in the office of Treasurer shall be filled by appointment by the Medical Executive Committee.

9.02 THE CHIEF OF STAFF

The Chief of Staff is the individual in charge of the Medical Staff organization, and, with assistance of the Medical Executive Committee, is responsible for the effective discharge of the functions of the Medical Staff as set forth in these Bylaws. The Chief of Staff shall receive such administrative support as necessary to the effective performance of his/her responsibilities.

9.02-1 DUTIES.

The Chief of Staff shall:

(a) Exercise such authority as he/she deems necessary so that at all times patient welfare takes precedence over all other concerns;

(b) In the interim between Medical Executive Committee meetings, perform those responsibilities of the Committee that, in his/her opinion, must be accomplished prior to the next regular or special meeting of the Committee;

(c) Appoint practitioners to such committees as he/she deems necessary to perform the functions of the Medical Staff organization;

(d) Report regularly to the Governing Body on the performance of all Medical Staff functions (as further described in Section 9.02-3), and communicate to the Staff any concerns expressed by the Governing Body with respect to the quality of medical care; and

(e) Be chairperson of the Medical Executive Committee and be an ex officio member of all Medical Staff committees.

9.02-2 AUTHORITY

The Chief of Staff shall have the authority:

(a) To summarily suspend Medical Staff members;

(b) To initiate appropriate corrective or disciplinary actions;

(c) To require consultations whenever, in his/her discretion, he/she deems it necessary;

(d) To appoint, in consultation with the Medical Executive Committee, the chairpersons and members of standing and special committees of the medical Staff;

(e) To appoint practitioners who are not members of the Medical Staff, to serve as special consultants to the Medical Executive Committee, or any other committee of the Medical Staff when deemed necessary or appropriate to assist such Committee with any peer review or quality assessment activities;

(f) To require that other Medical Staff officers and committee chairpersons assist him/her in performance of his/her responsibilities as Chief;

(g) To require all Staff members to comply with the Hospital and the Medical Staff Bylaws, Rules and Regulations, and policies and procedures, or face disciplinary action;

(h) To call special meetings of the Medical Executive Committee, any Staff committee, or of the Medical-Staff;

(i) To seek authorization from the CEO or from the Chairperson of the Governing Body to incur the expense of contacting legal counsel for assistance or guidance;

(j) Be designated to sign bank account checks on behalf of the Medical Staff;

(k) To act on behalf of the Medical Executive Committee whenever he/she determines that action is called for prior to the next regular or special meeting of the Medical Executive Committee; and

(l) To take whatever action reasonably necessary to the effective performance of his/her duties.

9.02-3 ACCOUNTABILITY AND RELATIONSHIPS

(a) The Chief of Staff shall be accountable to the Medical Staff and to the Governing Body. Accountability shall entail at least the following:

(1) The Chief of Staff shall regularly report to the Governing Body on the activities of the Medical Executive Committee as described in Section 10.02-5.

(2) The Chief of Staff shall keep the Chief Executive Officer informed of all violations of Medical Staff Bylaws and Rules and Regulations or of Hospital bylaws or policies which put patient welfare in jeopardy, and shall report on what action is being taken to prevent such incidents from recurring.

(3) The Chief of Staff shall report to the Chief Executive Officer concerning the progress being made toward attaining Medical Staff and Hospital objectives with respect to the Medical Staff organization.

(4) The frequency, type, and channel of reporting shall be determined by the Governing Body, based upon the recommendation of the Chief of Staff and the Chief Executive Officer.

(b) The Chief of Staff shall be the chairperson of the Medical Executive Committee and shall be the focal point for the Committee:

(1) Communications with the Governing Body.

(2) Communications with committee chairpersons

(c) All committee chairpersons shall be accountable to the Chief of Staff.

9.03 VICE-CHIEF OF STAFF (VICE-CHIEF)

The Vice-Chief of Staff is second in charge of the Medical Staff organization.

9.03-1 DUTIES

The Vice-Chief shall:

(a) In the absence or disability of the Chief of Staff, perform all of the duties of the Chief;

(b) Assist the Chief of Staff in the performance of his/ her duties; and

(c) Be a member of the Medical Executive Committee.

9.03-2 AUTHORITY

The Vice-Chief shall have the authority:

(a) When acting as the Chief of Staff or at the discretion of the Chief of Staff, to exercise all the authority of the Chief of Staff; and

(b) To initiate appropriate corrective or disciplinary actions.

9.03-3 ACCOUNTABILITY AND RELATIONSHIPS

The Vice-Chief of Staff shall be jointly accountable to the Chief of Staff and the Medical Executive Committee, and when acting as Chief of Staff he/she shall be accountable to the Governing Body and relate to the Staff and committees in the same manner as the Chief, as described in Section 9.02-3.

9.04 TREASURER

The Treasurer is responsible for the financial management of the Medical Staff revenues and expenses and will maintain bookkeeping records in good order including the Medical Staff bank account(s).

9.04-1 DUTIES

The Treasurer shall:

(a) Update the Medical Executive Committee on a monthly basis of any significant changes in Medical Staff financial assets.

(b) At least twice a year or as often as requested by the Chief of Staff provide a detailed report of Medical Staff revenues, expenses and account balances.

(c) Assist with other administrative and record keeping duties as assigned by the Medical Executive Committee.

9.04-2 AUTHORITY

The Treasurer shall:

(a) Be designated to sign bank account checks on behalf of the Medical Staff.

(b) Collect dues from Medical Staff members when authorized by the Medical Executive Committee to do so.

9.04-3 ACCOUNTABILITY AND RELATIONSHIPS

The Treasurer shall be jointly accountable to the Chief of Staff and the Medical Executive Committee.

ARTICLE 10: COMMITTEES

10.01 MEDICAL EXECUTIVE COMMITTEE

10.01-1 COMPOSITION

A. The Medical Executive Committee shall be comprised of the Medical Staff officers listed in Section 9.01-1. The Chief Executive Officer shall be an ex-officio member without vote. The Chief of Staff shall be chairperson of the Medical Executive Committee. At the discretion of the Chief of Staff, any other person may be invited to attend without vote.

B. At the discretion of the Chief of Staff, the following may be requested to attend to participate in discussions or give reports: the Director of Nursing, Pharmacist, Lab Manager, Radiology Manager, Respiratory Therapist, Physical Therapist, and EMS Director.

C. The Chief of Staff may convene an executive session of the Medical Executive Committee as needed with voting members only to be present.

D. Except as noted below, when the Medical Executive Committee members are present during a General Medical Staff meeting then the two meetings may occur concurrently. Any actions taken by either body will occur separately and will be documented in separate minutes. The foregoing does not apply to deliberations of the Medical Executive Committee that involve credentialing or other peer review matters.

E. Confidential peer review and other confidential information will not be discussed in the presence of individuals who are not members of the Medical Staff with the following exceptions: (1) the Chief Executive Officer; (2) the Chief Compliance Officer/Risk Manager (provided that peer review documentation may not be used or disclosed for risk management purposes); and (3) administrative staff designated by the Medical Executive Committee to support the committee's work.

10.01-2 PURPOSE

The purpose of the Medical Executive Committee is to assist the Chief of Staff and CEO in the development and implementation of policies, procedures, programs, rules, and regulations that accomplish the purposes and functions of the Medical Staff organization. The Committee shall also serve as the primary forum by which the Medical Staff formally participates in the Hospital budget, planning, and policymaking processes.

10.01-3 DUTIES

The Medical Executive Committee shall:

(a) Assist the Chief of Staff in supervising the performance of all Medical Staff functions, which shall include:

(1) Requiring regular reports and recommendations from the committees and officers of the Staff concerning discharge of assigned functions;

(2) Issuing such directives as appropriate to ensure effective performance of all Medical Staff functions; and

(3) Following up to ensure implementation of all directives.

(b) Make recommendations regarding all applications for Medical Staff appointment, reappointment and clinical privileges.

(c) In accordance with Article 6, initiate and/or pursue disciplinary or corrective actions affecting Medical Staff members.

(d) Assist the Chief of Staff in supervising the Medical Staff compliance with:

(1) The Medical Staff Bylaws, Rules and Regulations, policies, and procedures;

(2) Hospital Bylaws, Rules and Regulations, policies, and procedures;

(3) State and federal laws and regulations; and

(4) Accreditation requirements.

(e) Implement, as it relates to the Medical Staff, the medical care policies and procedures of the Hospital that have been approved by the Medical Executive Committee.

(f) Establish objectives for the maintenance and enforcement of professional standards within the Hospital, and for the continuing improvement of the quality of care rendered in the Hospital, and assist in developing programs to achieve these objectives.

(g) Regularly report to the Governing Body through the Chief of Staff and the Chief Executive Officer on at least the following:

(1) The outcomes of Medical Staff quality assessment programs with sufficient background and detail to assure the Governing Body that quality care is consistent with professional standards; and

(2) Any Medical Staff disciplinary or corrective actions in progress.

(h) Establish, subject to the approval of the Governing Body, such additional standing committees as necessary to carry out functions described in these Bylaws or otherwise assigned to or assumed by the Medical Staff.

(i) Establish, as necessary, such ad hoc committees which will function for limited times for the performance of circumscribed functions and which will report directly to the Medical Executive Committee.

(j) May meet concurrently with general Medical Staff meetings (except when performing credentialing activities) and as often as necessary and will maintain a permanent record of all meetings.

(k) Establish the date, place, time and agenda of the regular meetings of the Medical Staff, which shall be held monthly but, at the discretion of the Medical Executive Committee, such meetings may be more or less frequent as needed.

10.01-4 AUTHORITY

The Medical Executive Committee shall have the authority to:

(a) Summarily suspend any practitioner whenever the personal or professional conduct-of that member is such that a failure to take action may result in an imminent danger to the health of any individual.

(b) Require any practitioner to appear before the Committee whenever the Committee considers it necessary in order to carry out its duties and responsibilities.

(c) Establish subcommittees to study and advise on any matters before the Committee. Subcommittees may consist of practitioners other than those on the Medical Staff, but each subcommittee shall be chaired by a member of the Medical Staff.

(d) Take any action which the Committee deems necessary in discharging its duties and responsibilities.

10.01-5 ACCOUNTABILITY AND RELATIONSHIPS

The Medical Executive Committee is directly responsible and accountable to the Chief of Staff. The Medical Executive Committee shall report through the Chief of Staff

10.02 OTHER MEDICAL STAFF COMMITTEES, GENERAL, PROVISIONS

The Medical Executive Committee may establish committees to perform staff functions as it sees fit. The Medical Executive Committee may dissolve or rearrange the committee structure, duties or composition as needed to best accomplish the Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual or other committee shall be performed by the Medical Executive Committee.

The provisions set forth in this section (but not by way of limitation) apply to all committees of the Medical Staff.

10.02-1 COMPOSITION

Except as otherwise specifically noted in these Bylaws:

(a) All Medical Staff members of committees shall be appointed by the Chief of Staff in consultation with the Medical Executive Committee.

(b) The Chief of Staff and Chief Executive Officer shall be members, *ex officio*, without vote, on all committees, and may attend each committee meeting or have a designee attend for them.

(c) The chairperson of each committee shall be appointed by the Chief of Staff; the vice-chairperson may be elected from among the committee members.

(d) The Chief of Staff may appoint one or more Allied Health Professionals as voting or non-voting members of a committee.

10.02-2 TERM

(a) Committee members will be appointed to serve for two years, and may be reappointed to serve an additional consecutive two-year term.

(b) Committee chairpersons shall serve a two year term.

10.02-3 DUTIES

Each Staff committee is responsible to:

(a) Develop policies and procedures describing how it will carry out its purpose and, upon approval by the Medical Executive Committee and the Governing Body, implement the policies and procedures.

(b) Be aware of and use best efforts to assure compliance with applicable state and federal laws and regulations.

(c) Unless otherwise specified in these Bylaws, meet as often as necessary to fulfill its purpose.

(d) Unless otherwise provided by hospital policy, maintain permanent records of its activities in accordance with Section 11.02.

10.02-4 AUTHORITY

Each Staff committee shall have the following authority:

(a) To review all records and charts pertinent to the purposes of the committee and to perform quality assessment reviews as requested.

(b) To require the appearance before it of any practitioner or nurse whose conduct is being reviewed, or who has information relevant to the purposes of the committee.

(c) To request that the Chief of Staff and CEO appoint one or more special consultants, who need not be members of the Medical Staff, to assist in any peer review or quality assessment activities.

10.02-5 ACCOUNTABILITY AND RELATIONSHIPS

(a) Each committee shall be accountable to its chairperson.

(b) The chairperson of each committee shall be accountable to the Medical Executive Committee and the Chief of Staff.

(c) Each chairperson shall regularly report to the Medical Executive Committee, through the Chief of Staff.

10.03 CREDENTIALS COMMITTEE

10.03-1 COMPOSITION

The Credentials Committee shall be comprised of the Medical Executive Committee as a whole.

10.03-2 PURPOSE

The purpose of the Credentials Committee is to evaluate the qualifications of all applicants for Medical Staff appointment, reappointment, promotions, or changes in Medical Staff categories. The Committee shall coordinate the credentials review activities within the various departments, maintain records used in evaluation of applicants (with such records being stored in the Hospital), and shall develop recommendations based on its evaluations of each applicant.

10.03-3 OTHER

A confidential file on each applicant, Medical Staff member, and Allied Health Professional shall be maintained by the Credentials Committee in the Hospital. The application and all information obtained in conjunction with processing the application shall be Credentials Committee records. The Chief of Staff shall be the custodian of these records and will grant access to the CEO upon request.

10.04 MEDICAL STAFF PEER REVIEW COMMITTEE

10.04-1 COMPOSITION

The Medical Staff Peer Review Committee will be comprised of one Active Medical Staff member appointed by the Chief of Staff to be the chairperson and at least two other Medical Staff members. The Hospital Quality Assessment Coordinator and the Chief Compliance Officer/Risk Manager (or their designees) may be invited by the chairperson to participate to provide support and resources and to promote coordination of efforts, provided that peer review documentation may not be used or disclosed for risk management purposes.

10.04-2 PURPOSE

The purpose of the Medical Staff Peer Review Committee is: to improve patient care services; to assist in assessing Medical Staff performance in a manner which promotes continuous improvement; and to promote best practices, and compliance with evidence based medicine and national guidelines for patient care when appropriate. Summary reports of committee evaluations, deficiencies and progress reports on an institutional level will be supplied to the Hospital Quality Assessment Coordinator and CEO to support the Hospital program for Quality Improvement.

10.04-3 Meetings will be approximately every two months, or as often as needed.

ARTICLE 11: MEETINGS

11.01 GENERAL STAFF MEETINGS

11.01-1 REGULAR MEETINGS

The Medical Staff and Medical Executive Committee shall meet at least quarterly or as often as necessary. One of these meetings shall be designated as the "Annual Meeting."

11.01-2 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, the Medical Executive Committee or by a petition signed by not less than half of the active voting staff.

11.02 PROVISIONS COMMON TO ALL MEETINGS

11.02-1 NOTICE OF MEETINGS

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments and committees at least one week in advance of the meetings. Notice may also be provided by posting in a designated location or by email or telephone. All notices shall state the date, time, and place of the meetings.

(b) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

11.02-2 QUORUM AND VOTING

(a) For any regular or special meeting of the Medical Staff 5 Active Staff members, with at least 1 being a Medical Staff officer, shall constitute a quorum. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding.

(b) For any regular or special meeting of a Medical Staff committee, 50% of the voting members of the committee shall constitute a quorum.

(c) Recommendations and actions of the Medical Staff, departments and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of the voting Medical Staff members.

(d) The voting members of the Medical Staff, a department, or a committee may also be presented with a question by mail, facsimile, email, hand-delivery, or telephone, and their votes returned to the chairperson by the method designated in the notice. A quorum for purposes of these votes shall be the number of responses returned to the chairperson by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated.

(e) Meetings may be conducted by telephone conference in which each participant can hear and be heard by each other participant.

11.02-3 AGENDA

The presiding officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department or committee.

11.02-4 RULES OF ORDER

Robert's Rules of Order shall not be binding at Medical Staff meetings or elections, but may be used for reference in the discretion of the presiding officer for the meeting. Rather, specific provisions of these Bylaws and the Medical Staff department or committee custom shall prevail at all meetings. The committee chairperson shall have the authority to rule definitively on all matters of procedure.

11.02-5 MINUTES, REPORTS, AND RECOMMENDATIONS

(a) Minutes of all meetings of the Medical Staff, departments, and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the presiding officer.

(b) A summary of all recommendations and actions of the Medical Staff and committees shall be transmitted to the Medical Executive Committee and CEO. The Board shall be kept apprised of the recommendations of the Medical Staff and its and committees.

(c) A permanent file of the minutes of all meetings shall be maintained by the Medical Staff in the Medical Staff Office.

11.02-6 CONFIDENTIALITY

Members of the Medical Staff who have access to or are the subjects of credentialing and/or peer review information agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Medical Staff Bylaws or other applicable Medical Staff or Hospital policy. A breach of confidentiality may result in disciplinary action.

11.03 COMMITTEE MEETINGS

11.03-1 REGULAR MEETINGS

Committees will meet as often as members deem necessary according to the discretion of the committee chairman.

11.04 ATTENDANCE REQUIREMENTS

11.04-1 REGULAR ATTENDANCE

Each member of a Staff category required to attend meetings under Article 3 shall be required to attend 50% of regularly scheduled general Medical Staff meetings during the two-year reappointment period. For Active Staff Members who share a position with a contracted group such as hospitalists and ER Physicians, the number of required meetings will be 50% of the meetings that take place when they are on duty. Special meetings will count towards attendance credit but will not be counted as a required meeting.

11.04-2 FAILURE TO MEET ATTENDANCE REQUIREMENTS

Staff members will be notified annually if they have not yet met the full attendance requirements. Physicians who have not met meeting attendance requirements before the end of the appointment/reappointment period will be reappointed for a two-year period on probationary status. If the physician does not meet the meeting attendance requirements during the next two-year period, he/she will not be reappointed.

ARTICLE 12: IMMUNITY AND RELEASES

12.01 CONFIDENTIALITY, IMMUNITY AND RELEASES

12.01-1 GENERAL

Medical Staff or committee minutes, files and records, including applications and information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff committee files and shall not become part of any particular patient's file or the general Hospital files. Dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the Chief ofStaff.

12.01-2 BREACH OF CONFIDENTIALITY

Effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions. Accordingly, any breach of confidentiality of the discussions or deliberations of Medical Staff committees, except as required by court order, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

12.02 IMMUNITY FROM LIABILITY

12.02-1 FOR ACTION TAKEN

A. Applicants, members, and former members of the Medical Staff and individuals granted clinical privileges (referred to as "individuals" for purposes of this Section) release from any and all liability, extend immunity to the fullest extent permitted by law, and agree not to sue the Hospital, Medical Staff or Board, any Hospital employee or any member of the Medical Staff or Board, their agents or representatives, and third parties who provide information for:

(1) any action taken pursuant to these Bylaws related to appointment, reappointment, credentialing, privileging or peer review;

(2) providing information to a representative of any Medical Staff, Hospital, physician group, or any other third party concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this Hospital; and

(3) reports that are made to government regulatory and licensure boards or agencies pursuant to federal or state law.

B. Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in these Bylaws are the sole and exclusive remedy with respect to any professional review action taken at the Hospital.

C. Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting appointment or privileges, or any report that may be made to a regulatory board or agency, and does not prevail, he or she shall reimburse the Hospital, and any member of the Medical Staff or Board involved in the action, for all costs incurred in defending such legal action, including reasonable attorney's fees, expert witness fees, and lost revenues.

D. Scope of Section:

All of the provisions in this Section 12.02 apply:

(1) whether or not appointment or clinical privileges are granted;

(2) throughout the term of any appointment or reappointment period and thereafter;

(3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities;

(4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his or her tenure as a member of the Medical Staff; and

(5) as applicable, to any reports that may be made to government regulatory and licensing boards or agencies pursuant to federal or state law.

E. The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, department directors, committee chairpersons, committee members, and other authorized representatives when acting in those capacities, to the fullest extent permitted by law and as set forth in the Hospital corporate bylaws, provided there is no final adjudication finding by a court of law that such individuals engaged in intentional misconduct amounting to bad faith.

12.02-2 FOR PROVIDING INFORMATION

No representative of the Hospital or Medical Staff and no third party shall be liable for damages or other relief by reason of providing information (including otherwise privileged or confidential information) to a representative of this Hospital or Medical Staff or to any other hospital,

organization of health professionals, or other health-related organization concerning a practitioner who is or has been an applicant to or member of the Staff or who did or does exercise clinical privileges or provide specified services at this Hospital.

12.03 ACTIVITIES AND INFORMATION COVERED

12.03-1 ACTIVITIES

The immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health-related institution's or organization's activities concerning, but not limited to:

(a) Applications for appointment, clinical privileges, or specified services;

(b) Periodic reappraisals for reappointment, privileges, or specified services;

(c) Corrective action;

(d) Hearing and appellate reviews;

(e) Patient care audits;

(f) Utilization reviews;

(g) Peer Review Committee;

(h) Hospital Quality Assessment Program;

(i) Morbidity and mortality conferences; and

(j) Other Hospital or committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

12.03-2 INFORMATION

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or other matter that might directly or indirectly affect patient care.

12.04 RELEASES

Each practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article; however, execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

12.05 CUMULATIVE EFFECT

Provisions in these Bylaws and in Medical Staff application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

ARTICLE 13: GENERAL PROVISIONS

13.01 STAFF RULES AND REGULATIONS

Rules and regulations shall be developed as necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the clinical level of practice that is to be required of each Staff member or Allied Health Professional in the Hospital. The rules and regulations may be adopted, amended or repealed by majority vote of the Medical Executive Committee and approval of the Governing Body.

13.02 MEDICAL STAFF POLICIES

Policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Medical Staff rules and regulations. The policies may be adopted, amended or repealed by majority vote of the Medical Executive Committee. and approval by the Governing Body.

13.03 MEDICAL STAFF PARTICIPATION IN HOSPITAL DELIBERATIONS

Medical Staff representatives as designated by the Chief of Staff shall participate in any hospital deliberation affecting the discharge of Medical Staff responsibilities.

13.04 PROFESSIONAL LIABILITY INSURANCE

Each practitioner granted clinical privileges in the Hospital shall maintain in force professional liability insurance from a company authorized to sell insurance in the State of Nevada or from an insurance trust incorporated under the laws of one of the United States of America in no less than the minimum amounts, if any, as from time to time may be jointly determined by the Governing Body and Medical Executive Committee.

13.05 FORMS

Application forms and any other prescribed forms required by these Bylaws for use in connection with staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports, and other matters shall be developed by the Medical Staff and approved by the Governing Body. Upon adoption, they shall be deemed part of these Bylaws, except that they may be amended by approval of the Medical Executive Committee and the Governing Body.

13.06 HISTORIES AND PHYSICALS

(a) General Documentation Requirements

(1) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by the Hospital to perform histories and physicals.

(2) The scope of the medical history and physical examination will include, as pertinent:

- patient identification;
- chief complaint;
- history of present illness;
- review of systems;
- personal medical history, including medications and allergies;
- family medical history;
- social history, including any abuse or neglect;
- physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
- data reviewed;
- assessments, including problem list;
- plan of treatment; and
- if applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion which will be documented in the plan of treatment.

(3) In the case of a pediatric patient, the history and physical examination report must also include: (i) developmental age; (ii) length or height; (iii) weight; (iv) head circumference (if appropriate); and (v) immunization status.

(b) Individuals Who May Perform H&Ps

The following types of practitioners may perform histories and physicals at the Hospital if granted clinical privileges to do so:

(1) physicians;

[Insert list of other practitioners who are able to perform H&Ps]

(c) H&Ps Performed Prior to Admission

(1) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.

(2) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record by an individual who has been granted clinical privileges to complete histories and physicals.

(3) The update of the history and physical examination shall be based on an examination of the patient and must (i) reflect any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition.

(4) In the case of readmission of a patient, all previous records will be made available by the Hospital for review and use by the attending physician.

(d) Cancellations, Delays, and Emergency Situations

(1) When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, procedures performed in the operating suites, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until an appropriate history and physical examination is recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.

(2) In an emergency situation, when there is no time to record either a complete or a Short Stay history and physical, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending

physician is then required to complete and document a complete history and physical examination.

(e) Short Stay Documentation Requirements

A Short Stay History and Physical Form, approved by the MEC, may be utilized for (i) ambulatory or same day procedures, or (ii) short stay observations which do not meet inpatient criteria. These forms shall document the chief complaint or reason for the procedure, the relevant history of the present illness or injury, and the patient's current clinical condition/physical findings.

ARTICLE 14: ADOPTION AND AMENDMENT OF BYLAWS

14.01 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend Medical Staff Bylaws and amendments which shall be effective when approved by the Governing Body. If Governing Body has not acted (e.g., adopted, rejected, or proposed modifications) on the proposed amendment within 60 days, a meeting of the Joint Conference Committee shall be held within 10 days to work toward a consensus. The Governing Body's responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of a generally professionally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Governing Body.

14.02 METHODOLOGY

(a) All proposed amendments must be reviewed by the Medical Executive Committee prior to a vote by the Medical Staff. The Medical Executive Committee shall provide notice by reporting on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a majority of the voting active staff members.

(b) The Medical Executive Committee may present proposed amendments to the voting staff by electronic and regular mail ballot, returned to the Medical Staff Office by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the Active Staff eligible to vote.

(c) If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a joint conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its

contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within 30 days after receipt of a request for same submitted by the Chief of Staff.

14.03 MEDICAL STAFF DOCUMENTS

(a) In addition to the Medical Staff Bylaws, there shall be policies, procedures and rules and regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures and rules and regulations shall be considered an integral part of the Medical Staff Bylaws.

(b) Medical Staff documents other than the Medical Staff Bylaws may be amended by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists.

(c) Notice of all proposed amendments of such other Medical Staff documents shall be provided to each voting member of the Medical Staff at least 14 days prior to the Medical Executive Committee meeting when the vote is to take place and any Medical Staff member may submit written comments on the amendments to the Medical Executive Committee.

In recognition of the ultimate legal and fiduciary responsibility of the Governing Body, the organized Medical Staff acknowledges, in the event the Medical Staff has unreasonably failed to exercise its responsibility and after notice from the Governing Body to such effect including a reasonable period of time for response, the Governing Body may impose conditions on the Staff that are required for continued State licensure of the Hospital, approval by accrediting bodies or to comply with a court judgment. In such event, Staff recommendations and views shall be carefully considered by the Governing Body in its actions.

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter thereof.

The present Rules and Regulations of the Medical Staff are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended. To the extent they are inconsistent, the Rules and Regulations are of no force or effect.

ADOPTED BY THE MEDICAL STAFF ON:

_____, 2019

_____
Chief of Staff

APPROVED BY THE GOVERNING BODY AND EFFECTIVE AS OF:

_____2019

_____
Chair, Board of Trustees