MEDICAL STAFF BYLAWS

of

MEMORIAL HOSPITAL and HEALTH CARE CENTER
Jasper, Indiana

Approved by Medical Staff Executive Committee – September 21, 2010
(Approved by Medical Staff – March 29, 2011)
(Approved by Board of Directors – April 7, 2011)

Amended – 2016
(Approved by Medical Staff – January 26, 2016)
(Approved by Board of Directors – March 3, 2016)

Proposed Amendments – January 17, 2017
(Approved by Medical Staff – January 31, 2017)
(Approved by Board of Directors – April 6, 2017)

Amended – September, 2018
(Approved by Medical Staff – September 26, 2018)
(Approved by Board of Directors – November 1, 2018)

Amended – September, 2023
(Approved by Medical Staff – September 26, 2023)
(Approved by Board of Directors – October 5, 2023)

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PREAMBLE

Memorial Hospital and Health Care Center ("Hospital") is an acute care hospital that is organized and licensed under the laws of the State of Indiana, certified to participate in certain governmental health benefits programs by the Centers for Medicare and Medicaid Services and accredited by the Joint Commission.

The Hospital's Board of Directors ("Board") has established the Medical Staff as a constituent part of the Hospital and is not in any way intended to be a separate legal entity. The Medical Staff consists of those physicians and other practitioners who have been appointed to and granted the right to exercise certain clinical privileges in the Hospital.

The Board, in the exercise of its discretion, has identified certain purposes and delegated certain responsibilities to be performed by the Medical Staff. First, the Medical Staff is responsible for providing high quality, appropriate, and timely patient care and other professional services in the Hospital. The Medical Staff is also responsible for providing an appropriate setting for education, training, and research that fosters scientific standards and the continuous advancement in professional knowledge and skills of the Medical Staff and other health care professionals and students affiliated with the Hospital.

The Medical Staff is also responsible for providing advice to the Board concerning the structure and function of the Medical Staff, the delivery of high quality, appropriate, and timely patient care and other professional services rendered in the Hospital in addition to the significant business, professional, and clinical issues that impact the resources, relationships, and reputation of the Hospital and the Medical Staff.

The Medical Staff is a part of the Hospital's Organized Health Care Arrangement or "OHCA" in accordance with the Health Insurance Portability and Accountability Act, and all implementing regulations, as amended from time to time ("HIPAA"). The Hospital will issue a Joint Notice of Privacy Practices to all Hospital patients on behalf of the OHCA and all Medical Staff shall comply with all related Applicable Requirements (as defined herein).

Additionally, the Medical Staff is responsible for acting in good faith in the conduct of certain peer review activities and providing recommendations to the Board concerning the appointment or reappointment and the delineation of Clinical Privileges of all physicians and other practitioners, in addition to any related recommendations that could result in professional review or corrective action under these Bylaws. In so doing, the Hospital and its Board and Medical Staff, in addition to any other committee, person, or entity authorized to act for or on their behalf, shall qualify as a Peer Review Committee under I.C. §34-6-2-99, and as a professional review body

under 42 U.S.C. §11151(11), and hereby claim all privileges and immunities afforded them pursuant to these and any other Applicable Requirements.

Pursuant to I.C. §34-30-15-1, *et seq.*, no Peer Review Committee member, personnel or participant shall reveal the content of any related communications to, or the records or determinations of, the Peer Review Committee outside of the Peer Review Committee unless otherwise authorized by these Bylaws or other Applicable Requirements, however, the Board may disclose any final action taken with regard to the Medical Staff status or Clinical Privileges of a physician or other practitioner.

The Medical Staff shall accept and discharge these and other delegated responsibilities in accordance with these Medical Staff Bylaws and all other Applicable Requirements, as defined herein, subject to the ultimate authority of the Board.

APPROVED BY THE MEDICAL STAFF on
September 26, 2023

APPROVED BY THE BOARD OF DIRECTORS on
October 5, 2023

ARTICLE 1
DEFINITIONS

The following definitions shall apply to terms used in these Bylaws:

1. "Adversely Affect" or "Adversely Affecting" is defined as reducing, limiting, restricting, suspending, revoking, terminating, denying, withdrawing, refusing, deciding not to, or failing to renew.

2. "Affiliate" means an entity that is owned or otherwise affiliated with the Hospital and which employs or otherwise engages the services of Members on the Hospital's Medical Staff.

3. "Applicable Requirements" means all applicable laws, regulations, accreditation standards, third party payor requirements, Medical Staff Bylaws, Rules and Regulations and Hospital's Corporate Compliance Plan, Code of Conduct and all other policies, procedures and programs approved by the Board. This term also includes certain requirements set forth under the Health Care Quality Improvement Act of 1986 and the Indiana Peer Review Act that govern the conduct of any and all Peer Review, Corrective Action, hearings and appeals under these Bylaws, including, without limitation, the following:

- All Peer Review Activity, Corrective Action, and hearing and appeal procedures conducted hereunder (hereinafter collectively referred to as "Actions" for purposes of this provision) are taken:
    - In the reasonable belief that the Action is in the furtherance of quality health care;
    - After a reasonable effort to obtain the facts of the matter;
    - After adequate notice and hearing procedures are afforded to the Practitioner involved or after other procedures as are fair to the Practitioner under the circumstances; and
    - In the reasonable belief that the Action was warranted by the facts known after such reasonable effort to obtain facts and after the above requirements.
- No Practitioner who maintains Clinical Privileges which are in direct economic competition with a Practitioner who is the subject of an Action shall vote in any Action that concerns the subject Practitioner.
- No Practitioner who contributed to an initial request of Correction Action under Article 8 – Part D – Section 3 of these Bylaws shall participate in any subsequent Action that may result from the request.
- No Practitioner who initiated an Action or participated in any Action under these Bylaws shall participate in any subsequent Action that may concern a recommendation arising out of the original Action; provided, however, general

knowledge of a pending Corrective Action alone shall not preclude an individual from participating in any of the procedures that result from the Corrective Action.

- Any and all information, regardless of its form or medium, created or received in the conduct of Peer Review Activity by a Peer Review Committee shall be treated as privileged and confidential information and protected to the fullest extent in accordance with Applicable Requirements.

4. "Board" means the Board of Directors of the Hospital, which has the overall responsibility for the conduct of the Hospital, including the Medical Staff.

5. "Chief Executive Officer" means the president of the Hospital or such president's designee.

6. "Chief Medical Officer" means the Member, employed by the Hospital, to serve as the medico-administrative officer for the Hospital.

7. "Clinical Privileges" means the permission granted, including temporary privileges, to a Medical Staff Member or Medical Associate to render specific Hospital patient services and to utilize Hospital resources necessary to provide such services.

8. "Collegial Intervention" means an informal process by which Medical Staff Leadership or Administration works with a Practitioner to resolve conflict, correct behavior, or provide professional coaching in an effort to avoid formal corrective action.

9. "Conflict of Interest" means any business interest of an individual or the individual's immediate family member, specifically a spouse or natural born, adopted or step child, that may influence the individual's professional, ethical or independent judgment and decision-making or that may otherwise jeopardize the ability of the individual, the Hospital and/or the Medical Staff to comply with Applicable Requirements.

10. "Corrective Action" means an action or recommendation which is taken or made, which:

a. Is based on the competence or professional conduct of an individual Applicant or Appointee (which conduct affects or could Adversely Affect the health or welfare of a patient or patients, or which otherwise prove disruptive to Hospital operations); and

b. May or does Adversely Affect the current or requested Medical Staff membership or Clinical Privileges of the Applicant or Appointee in the Hospital, as appropriate.

Examples of "Corrective Action" that Adversely Affects the Medical Staff membership or Clinical Privileges of a Practitioner and triggers certain hearing and appeal rights under these Bylaws include, without limitation, the following recommendations or actions:

- Denial of initial appointment or denial of reappointment to the Medical Staff;

- Denial of initial application for certain Clinical Privileges, denial of application to expand current Clinical Privileges, or reduction of current Clinical Privileges;

- Suspension or revocation of Medical Staff membership or Clinical Privileges;

- Summary suspension of Clinical Privileges;

- Denial of a Practitioner's request for reinstatement following a leave of absence or the imposition of limitations or restrictions to the Practitioner's Medical Staff status or Clinical Privileges that were in place prior to the leave of absence;

- Establishment of a proctoring or supervising arrangement which requires the proctor to pre-approve and/or supervise a Practitioner's performance of certain Clinical Privileges or other treatment of patients; and

- A formal decision by the Hospital or the Medical Staff to accept the surrender of the Clinical Privileges of a Practitioner while the Practitioner is under investigation or in return for not conducting such an investigation or other Corrective Action.

For additional information and examples of Adverse Actions, see Chapter E (Reports) of the Guidebook published by the National Practitioner Data Bank online at http://www.npdb.hrsa.gov/resources/npdbguidebook.pdf.

Examples of Corrective Action that do not concern the competence or professional conduct of a particular Practitioner or which does not, in any way, reduce, limit, restrict, suspend, revoke, deny, terminate, or otherwise Adversely Affect the Medical Staff membership or Clinical Privileges of a Practitioner, and which does not trigger any hearing or appeal rights under these Bylaws, include, without limitation, the following recommendations or actions (hereinafter collectively referred to as "Non-Adverse Action" for purposes of this provision):

- Action unrelated to a Practitioner's competence or professional conduct, as in the case of an action concerned with any of the following:

    - The Practitioner's association, or lack of association, with a professional society or association;

    - The Practitioner's fees or the Practitioner's advertising or engaging in other competitive acts intended to solicit or retain business;

    - The Practitioner's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis;

    - The Practitioner's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with a member of a particular class of health care practitioner or professional; or

- Any other matter that does not relate to the competence or professional conduct of a Practitioner.

- Denial of Medical Staff appointment and/or certain Clinical Privileges because the Hospital's current Medical Staff includes sufficient practitioners practicing in Practitioner's discipline or scope of practice;

- Denial of application for Temporary Privileges;

- Reprimand or warning, whether oral or in writing;

- Automatic suspension of Clinical Privileges;

- Automatic termination of Medical Staff membership and/or Clinical Privileges upon the termination, expiration, or other conclusion of a Practitioner's employment by the Hospital or an Affiliate which required such Medical Staff membership and Clinical Privileges;

- Automatic termination of Medical Staff membership and/or Clinical Privileges due to the Practitioner's failure to secure or retain board certification to the extent required by these Bylaws;

- Probation;

- Retrospective or concurrent monitoring of a Practitioner or the creation of any proctoring or mentoring arrangement which does not require the proctor to pre-approve and/or supervise a Practitioner's performance of certain Clinical Privileges or other treatment of patients; or

- Requirement for Practitioner to submit to a physical or psychological examination in accordance with these Bylaws.

For additional information and examples of Non-Adverse Actions, go to Chapter E (Reports) of the Guidebook published by the National Practitioner Data Bank online at http://www.npdb.hrsa.gov/resources/npdbguidebook.pdf.

A Non-Adverse Action of an Applicant or Appointee is primarily based on:

- The Applicant's or Appointee's association, or lack of association, with a professional society or association;

- The Applicant's or Appointee's fees or the advertising or engaging in other competitive acts intended to solicit or retain business;

- The Applicant's or Appointee's participation in pre-paid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis;

- An Applicant's or Appointee's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care Practitioners or professionals; or

- Any other matter that does not relate to the competence or professional conduct of an Applicant or Appointee.

11. "Days" shall mean calendar days unless otherwise specified. If a due date falls on a Saturday, Sunday or legal holiday, in which event the due date shall be the first day immediately following which is not a Saturday, Sunday, or legal holiday.

12. "Executive Committee" means the Executive Committee of the Medical Staff unless specifically written "Executive Committee of the Board."

13. "Ex-officio" member means a nonvoting member of any designated body unless specified otherwise.

14. "Good Standing" means a Practitioner is in good standing when, at the time of the assessment or standing, the Practitioner's membership and Clinical Privileges are not voluntarily or involuntarily Adversely Affected for any cause or reason.

15. "Hospital" means the Memorial Hospital and Health Care Center located in Jasper, Indiana, including any all inpatient and outpatient facilities operated under the Hospital's license.

16. "Hospital Administration" means the Senior Executive team of Memorial Hospital and Health Care Center, including the President/CEO, Vice-Presidents, and members of Administrative Staff.

17. "Hospital Management" means the Hospital Administration and Department Directors of Memorial Hospital and Health Care Center.

18. "Impaired Practitioner" means a Practitioner who suffers from (a) a physical disability, or (b) a mental disability or disorder listed in the Diagnostic and Statistical Manual of Mental Disorders ("DSM-IV"), including but not limited to, deterioration through the aging process or loss of motor skill, or (c) a substance-related disorder listed in the DSM-IV, including but not limited to, abuse of or severe dependency upon alcohol or other drugs, or (d) any combination thereof, any of which endanger the public by impairing the Practitioner's ability to practice safely.

19. "Licensing Board" means the Indiana state licensing board responsible for the issuance and any resulting disciplinary action of a professional license of a Practitioner under these Bylaws.

20. "Medical Assistant" means a duly qualified individual, including but not limited to, social workers, registered nurses, licensed practical nurses, and surgical scrub technicians not a member of the Medical Staff or an employee of the Hospital, who may apply for or who has been provided with a written delineation of the scope of activities such individual is permitted to undertake at the Hospital under the responsibility and supervision of a designated Member of the Medical Staff.

21. "Medical Associate" means those duly qualified nurse practitioners, clinical nurse specialists, physician assistants, certified registered nurse anesthetists, clinical psychologists, licensed clinical social workers, and other classes of health care professionals approved by the Board, who may apply for or who has been granted Clinical Privileges by the Board to render specific professional services at the Hospital, either independently or under the responsibility and supervision of a designated Member of the Medical Staff. *Note: For any Medical Associates employed by and subject to a job description adopted by the Hospital, any application to perform professional services under the supervision of the Medical Staff shall include a copy of their job description and scope of work all of which shall be supervised by, or acting in collaboration with, at least one or more Physicians, as assigned by the Board. Any such scope of work shall expire upon conclusion of any Hospital employment of the Medical Associate.*

22. "Medical Staff" or "Medical Staff Applicant" or "Applicant" or "Medical Staff Appointee" or "Appointee" or "Medical Staff Member" or "Member" means all Physicians, dentists, podiatrists, oral surgeons and Medical Associates who apply for or are granted Clinical Privileges to treat patients in the Hospital.

23. "Medical Staff Coordinator" means the individual who is employed by the Hospital to carry out the functions of the Medical Staff Office, and reports to the Director of Quality Services and ultimately the Chief Medical Officer, who provides oversight.

24. "National Practitioner Data Bank" or "Data Bank" means that confidential information clearinghouse created by the federal government with the primary goals of improving health care quality and issuing reports regarding adverse actions that may involve Medical Staff under these Bylaws.

25. "Oral Surgeon" means a licensed dentist who has successfully completed a post-graduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education.

26. "Peer Review" or "Peer Review Activity" includes, without limitation, the evaluation of (a) qualifications, competence, and professional conduct of individual Practitioners, and (b) the merits of any complaint or other facts and circumstances which concerns the Practitioner's qualifications, competence, or professional conduct, any of which could Adversely Affect the health or welfare of the public. Professional conduct may include a Practitioner's inappropriate use of social media, as defined in the Hospital's Social Media Policy. The Peer Review process also includes Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) to evaluate and determine a particular Practitioner's professional and behavioral performance. The conduct of Peer Review proceedings involves the creation or receipt of confidential communications, documents, including but not limited to,

agendas, minutes and reports, and other information that is privileged and not otherwise disclosed unless otherwise required or permitted in accordance with these Bylaws, I.C. §34-30-15-1, *et seq.*, or other Applicable Requirements.

27. "Peer Review Committee" means any committee that conducts Peer Review Activity, including without limitation the Hospital and its Board and any other Hospital or Medical Staff committee that is organized by the Hospital or Medical Staff to conduct Peer Review. A Peer Review Committee has the responsibility of evaluation of: (a) qualification of professional health care providers; (b) patient care rendered by professional health care providers; or (c) the merits of a complaint against a professional health care provider that includes a determination or recommendation concerning the complaint, and the complaint is based on the competence or professional conduct of an individual health care provider, whose competence or conduct affects or could Adversely Affect the health or welfare of a patient or patients; and meets the criteria set forth in I.C. §34-6-2-99. A Peer Review Committee may also include personnel, which means not only members of the Peer Review Committee but also all of the committee's employees, representatives, agents, attorneys, investigators, assistants, clerks, and any other person or organization who serves as a Peer Review Committee in any capacity. A Peer Review Committee shall also qualify as a professional review body under 42 U.S.C. § 11151(11) and hereby claim all privileges and immunities available per Applicable Requirements.

28. "Performance Improvement" refers to activities related to the continuous improvement of care and the assurance of quality of care in the Hospital and its related activities, and includes such activities when referred to by other terms, such as, but not limited to, quality assurance, quality assessment, continuous quality improvement, and total quality management.

29. "Physicians" shall be interpreted to include both doctors of medicine (M.D.) and doctors of osteopathy (D.O.) who are licensed to practice medicine in the State of Indiana without limitation or qualification.

30. "Practitioner," unless otherwise expressly limited by the Bylaws, means any Physician, dentist, oral surgeon, podiatrist, or Medical Associate, who is applying for or exercising certain Clinical Privileges, or any Medical Assistant who is applying for or performing certain delineated scope of activities at the Hospital (or any individual who, without authority, holds such individual out to be so authorized).

31. "President" means the Member serving as president of the Medical Staff. In the President's absence, which includes due to a physical or mental impairment or disability, this term shall mean the Vice President of the Medical Staff. In the absence of the President and the Vice President of the Medical Staff, this term shall mean the Secretary-Treasurer of the Medical Staff.

32. "Quality Council" means the Hospital committee charged with the guidance of overall Hospital wide Quality Assessment/Performance Improvement activities as more particularly described in the Quality Assessment/Performance Improvement Plan of the Hospital.

33. "Residents" means Physicians in training who are currently enrolled in a graduate medical education program and who, as part of their educational program, provide health care service at the Hospital under the supervision and direction of members of the Medical Staff.

Residents are not considered members of the Medical Staff and are not entitled to rights and privileges under the Medical Staff Bylaws, including the right to a hearing and appellate review of adverse actions under Article 9. Residents must hold or secure, and maintain, either a permanent or temporary license to practice medicine from the Indiana Medical Licensing Board. Residents may write all types of diagnostic and treatment orders for patients without being required to obtain a countersignature from a supervising physician except as may be otherwise specified in the Medical Staff or departmental rules and regulations.

34. "Special Notice" means a written notification sent by certified or registered mail, return receipt requested. This term may also include personal, hand-delivery of a written notification which is confirmed with a signed receipt. Special Notice is complete upon mailing or delivery, as appropriate.

35. Words used in these Bylaws shall be read as the masculine, feminine or neutral gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

ARTICLE 2
CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be made by the Board upon recommendation of the Medical Staff Credentials Committee and Executive Committee and shall be to one of the following categories of the Medical Staff, except as otherwise provided in this Article, all upon receipt of a completed application for appointment or reappointment, pursuant to these Bylaws.

ARTICLE 2 - PART A: ACTIVE STAFF

The Active Staff shall consist of those Appointees who have satisfied all minimum qualifications under Article 7 herein, and who actually attend, admit, or are involved in the treatment of at least twenty-five (25) Hospital patients per calendar year or alternatively, those Appointees who actually work at least twelve (12), eight (8) hour shifts per year at the Hospital in the treatment of patients, and maintain a primary practice within the service area of the Hospital. Any Active Staff Member who fails to meet at least one of these minimum Hospital activity levels during a particular calendar year will be granted a one (1) calendar year "grace period" to attain the activity level that corresponds to the Appointee's desired Medical Staff category. *NOTE: For purposes of this Article, the term "Hospital" shall include any inpatient or outpatient facility operated under the Hospital's license.* Each Appointee to the Active Staff shall agree to assume all the functions and responsibilities of appointment to the Active Staff. Additional functions and responsibilities of the Active Staff Appointees will be determined by the respective department, Medicine or Surgery (defined herein). All Active Staff are encouraged to participate in the formal medical education programs of the Hospital. Active Staff Appointees shall be entitled to vote, hold office, serve on Medical Staff committees, and serve as chairperson of a department or committee. They shall be encouraged to attend Medical Staff, department, and any assigned committee meetings, and are required to provide after-hours call coverage in their specialty in accordance with Applicable Requirements, including but not limited to, Emergency Medical Treatment and Active Labor Act ("EMTALA"). Active Staff Members attaining the age of sixty-seven (67) will no longer be required to participate in the ER call schedule.

It is the expectation that Active Staff Physicians on the Emergency Department call schedule will maintain offices or residences which, in the opinion of the Executive Committee, are close enough to the Hospital to provide appropriate continuity of care. All Active Staff will respond to pages or calls from the Emergency Department in a timely manner, but no later than thirty (30) minutes after the page or call has been initiated by the Emergency Department. At the time of the response call, the responding Physician and the Emergency Department Physician will agree upon a plan of care for the patient. The responding Physician is then expected to physically respond to the Emergency Department in a timely manner but no later than within sixty (60) minutes after the response call or such other timeframe agreed to by the responding Physician and the Emergency Department Physician.

Any Active Staff Member listed on any established call schedule who, in the opinions of both the chairperson of the department and the President, is determined to have failed to fulfill the responsibilities of Emergency Department call on two (2) separate and unrelated occasions in any twelve (12) month period of time will be asked to appear before the Executive Committee for further consideration and resolution.

ARTICLE 2 - PART B: COURTESY STAFF

The Courtesy Staff shall consist of those Appointees who have satisfied all minimum qualifications under Article 7 herein and who actually attend, admit, or are involved in the treatment of not more than twenty-five (25) patients per calendar year at the Hospital, or alternatively, those Appointees who actually work not more than twenty-five (25), eight (8) hour shifts per year at the Hospital in the treatment of patients. Any Courtesy Staff who exceeds either of these maximum Hospital activity levels will be automatically advanced to the Active Staff during the next reappointment cycle. Any Courtesy Staff Appointee, not otherwise employed by the Hospital, shall also maintain Medical Staff membership and Clinical Privileges, in Good Standing, with at least one (1) other acute care hospital or other equivalent, accredited organization that is subject to a patient care audit program and other quality maintenance activities similar to those conducted by the Hospital, prior to any actions that may result in automatic advancement to Active Staff status. *NOTE: For purposes of this Article, the term "Hospital" shall include any inpatient or outpatient facility operated under the Hospital's license.* Each Appointee to the Courtesy Staff shall agree to assume all the functions and responsibilities of appointment to the Courtesy Staff. Additional functions and responsibilities of the Courtesy Staff Appointees will be determined by the respective department. All Courtesy Staff are encouraged to participate in the formal medical education programs of the Hospital. Courtesy Staff Appointees shall not be entitled to vote, hold office, serve on Medical Staff committees or serve as chairperson of a department or committee. However, they are permitted (and encouraged), but not required to, attend Medical Staff, department, and any assigned committee meetings. Courtesy Staff Appointees are not required to provide after-hours call coverage in accordance with Applicable Requirements, including but not limited to EMTALA.

ARTICLE 2 - PART C: HONORARY STAFF

The Honorary Staff shall consist of Appointees who have retired from active practice and any other Physicians, dentists, oral surgeons, podiatrists or other licensed health care professionals, approved by the Board, who are of outstanding reputation, and not necessarily residing in the community. Honorary Staff may not vote, hold office, serve on any Medical Staff committee or admit patients to the Hospital. Honorary Staff are not required to pay dues. However, the President may appoint them to serve on special committees and they are encouraged to attend Medical Staff meetings.

ARTICLE 2 - PART D: EXCLUSIVITY POLICY

In recognition of the Hospital's policy that certain Hospital facilities shall be used on an exclusive basis in accordance with contracts between the Hospital and qualified Appointees, such that other Appointees must (except in emergency or life threatening circumstances) adhere to this exclusivity policy in arranging for the care of their patients, applications for initial appointment or for Clinical Privileges related to those Hospital facilities and services will not be accepted for processing unless submitted in accordance with an existing or proposed contract with the Hospital. The Hospital shall inform the Medical Staff of the facilities and services that shall be used on an exclusive basis. An Appointee who is or who will be providing specified professional services pursuant to a contract with the Hospital must meet the same membership qualifications, must be processed for appointment, reappointment, and awarded Clinical Privileges in the same manner and must fulfill all of the obligations of such Appointee's membership category as any other Applicant or Medical Staff Appointee. Following any termination or other expiration of a particular contract, the continuation of the Appointee's appointment status and Clinical Privileges shall be governed by the terms of the applicable contract executed by the Appointee and the Hospital, however no such contract may reduce any hearing rights granted to a particular Appointee when any termination involves a recommended Corrective Action that, upon approval by the Board, would require a report to a particular Licensing Board and/or the National Practitioner Data Bank.

ARTICLE 3
MEDICAL ASSOCIATES AND MEDICAL ASSISTANTS

ARTICLE 3 – PART A: MEDICAL ASSOCIATES

Section 1 Qualifications:

a) Nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, physician assistants, licensed clinical social workers, clinical psychologists, and other classes of health care professionals approved by the Board, who have been licensed or certified by their respective licensing or certifying agencies and who desire to provide professional services in the Hospital, are eligible to serve as Medical Associates pursuant to requirements adopted by the Board and Applicable Requirements.

b) Each such individual shall file an application on a form provided by the Hospital. Each applicant shall be evaluated by the Credentials Committee, which shall recommend to the Board the scope of practice that the Applicant shall be permitted to exercise in the Hospital either in general or limited to a particular case. The Applicant and any applicable supervising or collaborating Physician(s) shall have the right to appear personally before the Credentials Committee to discuss the Clinical Privileges recommended by the Credentials Committee before that recommendation is transmitted to the Board.

Section 2 Conditions of Service:

a) Medical Associates shall *not* be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff and may only engage in acts within the scope of practice or Clinical Privileges specifically granted by the Board in accordance with Applicable Requirements. They shall be located close enough to the Hospital to fulfill their responsibilities, and to provide timely care for their patients in the Hospital.

b) Medical Associates shall be entitled to take advantage of the provisions of the hearing and appeal rights and procedures set forth in Article 9 of these Bylaws to the extent such provisions are applicable to Medical Associates and not in conflict with any of the provisions of this Article 3.

c) The number of Medical Associates acting as employees of one-Appointee, as well as the acts they may undertake, shall be consistent with Applicable Requirements in addition to the Bylaws, Rules and Regulations of the Medical Staff, and the policies of the Hospital and its Board.

ARTICLE 3 - PART B: MEDICAL ASSISTANTS

Section 1 Qualifications:

Categories of health care professionals recommended by the Medical Staff and approved by the Board who are licensed or certified by their respective licensing or certifying agencies and/or who provide services as employees of or under the supervision of a designated Appointee of the Medical Staff are eligible to serve as Medical Assistants pursuant to requirements adopted by the Board and Applicable Requirements.

Section 2 Selection Procedure:

The Credentials Committee, on the recommendation of the chairperson of the applicable department, shall recommend to the Board a written delineation of the scope of activities each Medical Assistant is permitted to undertake in the Hospital. In formulating this recommendation, the Credentials Committee shall receive, on a form approved by the Board, sufficient information about the qualifications of that individual to permit the Credentials Committee to recommend the scope of activities the individual will be permitted to undertake in the Hospital. The form shall be prepared and signed by the Medical Assistant and at least one (1) designated Active Staff Appointee of the Medical Staff. The designated Appointee of the Medical Staff seeking to employ or supervise the Medical Assistant in the Hospital shall have the opportunity to appear before the Credentials Committee and discuss the proposed delineation before any final action is taken on it by the Board. The Medical Assistant may act in the Hospital pursuant to the approved delineation only so long as such Medical Assistant is employed or otherwise supervised by the designated Appointee(s) of the Medical Staff in a manner consistent with Applicable Requirements.

Section 3 Conditions of Service:

a) Medical Assistants shall not be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff and may only engage in acts within the scope of practice specifically granted by the Board in accordance with Applicable Requirements.

b) Medical Assistants shall be entitled to take advantage of the provisions of the hearing and appeal rights and procedures set forth in Article 9 of these Bylaws to the extent such provisions are applicable to Medical Assistants and not in conflict with any of the provisions of this Article 3.

c) Any activities permitted by the Board to be done in the Hospital by Medical Assistants shall be done only under the direct and immediate supervision of their employer or supervising Appointee. However, “direct and immediate supervision” shall not require the actual physical presence of the Appointee. Should any Hospital employee who is licensed or certified by Indiana have any question regarding the clinical competence or authority of the Medical Assistant either to act or to issue instructions outside the physical presence of the employer or supervising Appointee in a particular instance, such Hospital employee has the right to require that the Appointee validate, either at the time or later, the instructions of the

Medical Assistant. Any act or instruction of the Medical Assistant shall be delayed until such time as the Hospital employee can be certain that the act is clearly within the scope of the Medical Assistant's activities as permitted by the Board. At all times the employing or supervising Appointee will remain responsible for all acts of any of their Medical Assistants within the Hospital.

d) The number of Medical Assistants acting as employees of one Appointee, as well as the acts they may undertake, shall be consistent with Applicable Requirements in addition to the Bylaws, Rules and Regulations of the Medical Staff, and the policies of the Hospital and its Board.

e) It shall be the responsibility of the Appointee to provide professional liability insurance for such Medical Assistant to carry his/her professional liability insurance in amounts required by the Board that covers any activities in the Hospital and furnish evidence of such to the Hospital so that it can be ascertained that such professional liability insurance covers the activities of the Medical Assistant in the Hospital and such Medical Assistant shall act in the Hospital only while such coverage is in effect.

ARTICLE 4
STRUCTURE OF THE MEDICAL STAFF

ARTICLE 4 - PART A: GENERAL

Section 1 Medical Staff Year:

For the purpose of these Bylaws, the Medical Staff year commences on the 1st day of January and ends on the 31st day of December each year.

Section 2 Dues:

All persons appointed as Active or Courtesy Members to the Medical Staff pay annual staff dues to the Hospital's Medical Staff account as may be required by the Executive Committee and approved by the Medical Staff. Signatories to this account shall be the President and the Treasurer.

ARTICLE 4 - PART B: OFFICERS

The officers of the Medical Staff shall be the President, Vice President and Secretary-Treasurer. Officers must maintain an appointment to the Active Staff in Good Standing, without restriction, at the time of nomination and election and throughout all terms of office. Failure to maintain such status shall result in the immediate removal of the particular officer by the President, or alternatively the Chief Executive Officer if necessary, and create a vacancy in the office involved.

Candidates for the office of President shall also be eligible to vote, have been a Member of the Medical Staff for at least three (3) years, served as a Member of the Executive Committee for at least two (2) years, be willing to assume the responsibility of the office and must be willing and able to discharge the duties of the office held.

Candidates for the office of Vice President shall also be eligible to vote, have been a Member of the Medical Staff for at least three (3) years, served as a Member of the Executive Committee for at least one (1) year, be willing to assume the responsibility of the office and must be willing and able to discharge the duties of the office held.

Candidates for the office of Secretary-Treasurer shall also be eligible to vote, have been a Member of the Medical Staff for at least three (3) years, be willing to assume the responsibility of the office and must be willing and able to discharge the duties of the office held.

Section 1 President:

The President shall:

a) Call, preside at and be responsible for the agenda of all general meetings of the Medical Staff;

b) Make recommendations for appointment of committee chairpersons and members, in accordance with the provisions of these Bylaws, to all standing and special Medical Staff committees except the Executive Committee;

c) Serve as Chairperson of the Executive Committee;

d) Serve as ex-officio member of all Medical Staff committees other than the Executive Committee;

e) Represent the views, policies, needs and grievances of the Medical Staff and report on the medical activities of the staff to the Board and to the Chief Executive Officer;

f) Provide day-to-day liaison on medical matters with the Chief Executive Officer and the Board;

g) Call for and conduct Collegial Interventions involving individual Practitioners;

h) Receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide medical care; and

i) Enforce these Bylaws.

Section 2 Vice President:

The Vice President shall:

a) Assume all the duties and have the authority of the President in the event of the President's temporary inability to perform due to illness, being out of the community or being unavailable for any other reason;

b) Be a member of the Executive Committee;

c) Automatically succeed the President when the President fails to serve for any reason;

d) Call for and conduct Collegial Interventions involving individual Practitioners;

e) Perform such duties as are assigned to the Vice President by the President; and

f) Be the President-Elect, assuming the role of President when the role becomes vacant.

Should both the President and the Vice-President be unavailable in an emergency, the authority and duties of the President will be temporarily assumed by the Secretary-Treasurer, or alternatively, the immediate past president.

Section 3 Secretary-Treasurer:

The Secretary-Treasurer shall:

a) In the event of the temporary inability of both the President and the Vice-President to perform, assume all the duties and have the authority of the President in the event of the President's temporary inability to perform due to illness, being out of the community or being unavailable for any other reason;

b) Serve on the Executive Committee;

c) Collect staff dues and make disbursements authorized by the Executive Committee or its designees;

d) Maintain financial records and pay expenses;

e) Call for and conduct Collegial Interventions involving individual Practitioners; and

f) Keep accurate and complete minutes of all meetings of the Medical Staff.

Section 4 Election of Officers:

a) At least one (1) month before the scheduled date of the next Medical Staff election, the President shall appoint a Nominating Committee consisting of five (5) Active Staff Appointees. The Nominating Committee shall prepare a slate of nominees for each office.

b) Nominations for officers of the Medical Staff shall be presented by the Nominating Committee and from the floor at each annual meeting. The candidates who receive a majority vote of those Medical Staff Appointees eligible to vote and present at the meeting at the time the vote is taken shall be elected, subject to approval by the Board. The Board shall not withhold approval of the Medical Staff officers without reasonable cause.

c) In any election, if there are three (3) or more candidates for an office and no candidate receives a majority, there shall be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one (1) candidate.

d) Each elected officer shall serve from the start of the next Medical Staff year for a term of one (1) year or until any such selected officer's successor has been elected.

Section 5 Removal of Officers:

a) An officer may be removed from office by either the Medical Staff or the Executive Committee, and the Board, for failure to perform the obligations and responsibilities of the particular office as required by the Medical Staff Bylaws and

other policies, procedures, and resolutions of the Medical Staff, the Board and the Hospital.

b) An officer may be removed from office by the Medical Staff as a result of a petition of at least twenty-five percent (25%) of the Active Medical Staff Members in Good Standing, and at least a two-thirds (2/3) majority vote of the Active Medical Staff Members in Good Standing who are present to vote during a regular or special meeting of the Medical Staff called for such purpose by the Executive Committee. The officer in question shall not be present during the Medical Staff meeting. No such removal by the Medical Staff shall be effective unless and until the action has been approved by the Board.

c) An officer may also be removed from office by a two-thirds (2/3) majority vote of the Executive Committee, or a majority vote of the Board. No such removal by the Executive Committee shall be effective unless and until the action has been approved by the Board.

Section 6 Vacancies in Office:

If there is a vacancy in the office of the President prior to the expiration of the President's term, the Vice-President shall assume the duties and authority of the President for the remainder of the unexpired term. If there is a vacancy in any other office, the Executive Committee shall appoint another Active Staff Appointee to serve out the remainder of the unexpired term.

ARTICLE 4 - PART C: MEETINGS OF THE MEDICAL STAFF

Section 1 Annual Staff Meeting:

The Medical Staff shall hold its Annual Meeting in September at which time officers for the ensuing year shall be elected.

Section 2 Regular Staff Meetings:

The Medical Staff shall hold at least two (2) meetings per year, on dates, times, and locations set at the beginning of the year by the President, for the purpose of reviewing and evaluating service and committee reports and recommendations, and to act on any other matters placed on the agenda by the President.

Section 3 Special Staff Meetings:

Special meetings of the Medical Staff may be called at any time by the President, a majority of the Executive Committee or a petition signed by not less than one-fourth (1/4) of the voting staff. In the event that it is necessary for the Medical Staff to act on a question without being able to meet, the Medical Staff eligible to vote may be presented with the question by mail or email and their votes returned to the President by mail or email. Such a vote shall be valid so long as the question is voted on by a majority of the Medical Staff eligible to vote.

Section 4 Quorum; Action:

A quorum is required to vote on matters before the Medical Staff. The presence of one-half (1/2) of the persons eligible to vote shall constitute a quorum for any regular or special meeting of the Medical Staff. The action by a majority of those Medical Staff Members eligible to vote, and who are present at a Medical Staff meeting at which a quorum is present, shall be the action of the Medical Staff.

Section 5 Attendance:

All Active Staff Appointees are encouraged to attend meetings of the Medical Staff, their assigned department, and assigned committees.

Section 6 Minutes:

Minutes of each meeting of the Medical Staff shall be prepared and shall include a record of the attendance of Members, the recommendations made and of all votes taken on each matter. The minutes shall be signed by the President and copies thereof shall be promptly forwarded to the Executive Committee and at the same time to the Chief Executive Officer.

ARTICLE 4 - PART D: DEPARTMENT AND COMMITTEE MEETINGS

Section 1 Department Meetings:

Members of each department shall meet as a department on an as needed basis at a time set by the chairperson of the department to review and evaluate the clinical work of the department, to consider the findings of ongoing quality assessment activities, and to discuss any other matters concerning the department. The agenda for the meeting and its general conduct shall be set by the chairperson.

Section 2 Committee Meetings:

All committees shall meet at least quarterly, unless otherwise specified, at a time set by the chairperson of the committee. The agenda for the meeting and its general conduct shall be set by the chairperson.

Section 3 Special Department and Committee Meetings:

a) A special meeting of any committee or department may be called by or at the request of the chairperson, by the Chief Executive Officer, by the President, or by a petition signed by not less than one-fourth (1/4) of the members of the department or committee.

b) In the event that it is necessary for a committee or department to act on a question without being able to meet, the voting members may be presented with the question, in person, by email or by mail, and their vote returned to the chairperson of the committee or chairperson of the department. Such a vote shall be binding so long

as the question is voted on by a majority of the committee or department eligible to vote.

Section 4 Quorum; Action:

a) The presence of one-fourth (1/4) of the total membership of the committee or department eligible to vote at any regular or special meeting (but in no event less than two (2) members) shall constitute a quorum for any regular or special committee or department meeting. A quorum is required to vote on matters before a particular department or committee. The action by a majority of those persons eligible to vote, who are present at a meeting at which a quorum is present, shall be at the action of the particular committee or department.

b) The Credentials Committee requires the presence of one-half (1/2) of the total membership of the Credentials Committee eligible to vote at any regular or special meeting (but in no event less than four (4) members) for a quorum for any regular or special committee meeting.

Section 5 Peer Review Requests:

a) From time to time, a department or committee may request a Peer Review for the purpose of reviewing facts and circumstances that may question the qualifications, competence, or professional conduct of an Appointee or Applicant. These requests will be made to the Surgical Quality Assessment/Performance Improvement Committee or the Medicine Quality Assessment/Performance Improvement Committee as appropriate. In order to assure the confidentiality of all communications, documentation, reports, minutes, and other information created or received during the conduct of these "Peer Review Committee" sessions, all department and committee members and staff shall agree to maintain confidentiality regarding information shared or discussed in those meetings. All Peer Review findings, recommendations, and reports by the Surgical Quality Assessment/Performance Improvement Committee and the Medicine Quality Assessment/Performance Improvement Committee will be submitted to the Medical Staff Peer Review Committee described in Article 6 (I).

b) From time to time, a department or committee member may be in direct economic competition with, or have such other Conflict of Interest in any matter involving another Appointee or Applicant that comes before the department or committee, or alternatively, the Member may communicate facts or circumstances to the chairperson that question the qualifications, competence, or professional conduct of the Appointee or Applicant. Under these circumstances, the Member may be asked to discuss any questions regarding the matter or the Conflict of Interest with the membership, but shall not otherwise participate in the discussion or voting on the matter.

c) Any subject Appointee or Applicant who is scheduled to appear at a department or committee meeting for the purpose of reviewing facts and circumstances that may

question their qualifications, competence, or professional conduct shall be notified in advance and the chairperson of that committee shall request the subject Appointee or Applicant to attend such meeting. The Special Notice shall be labeled "Peer Review Privileged and Confidential" and shall include the time and place of the meeting, a statement that the subject Appointee's or Applicant's attendance is requested, and whenever there are questions concerning the subject Appointee's or Applicant's competence or professional conduct, the Special Notice shall so state.

d) In all other cases, if the subject Appointee or Applicant shall make a timely request for postponement supported by an adequate showing that such Appointee's or Applicant's absence will be unavoidable, the presentation may be postponed by the chairperson of the department or committee involved or by the President, if the chairperson of the department or committee is the subject Appointee in question, until not later than the next regularly scheduled meeting. Otherwise, the pertinent facts and circumstances related to any questions concerning the qualifications, competence, or professional conduct of the subject Appointee or Applicant shall be presented and discussed, as scheduled, prior to any action or recommendation by the particular department or committee.

e) Persons appointed to the Courtesy categories of the Medical Staff who are invited to attend a department or committee meeting to address matters unrelated to any question concerning their competence or professional conduct shall be expected to attend unless unavoidably prevented from doing so, however, any such failure to attend shall be accommodated and shall not interfere with their continued Medical Staff appointment.

Section 6 Minutes and Reports:

a) Minutes of each meeting of every committee and department shall be prepared and shall include a record of the attendance of members, of the recommendations made and of all votes taken on each matter. All minutes shall be signed by the chairperson of each committee and department and maintained in a permanent file.

b) For any special "Peer Review Committee" sessions that are conducted during a committee or department meeting, the related portions of the minutes and any documentation reviewed during the session shall be recorded in a separate document that is stamped "Peer Review Privileged and Confidential" and attached to the minutes.

c) A copy of all minutes shall be promptly forwarded to the President and the Chief Executive Officer.

d) A copy of minutes from any special "Peer Review Committee" session shall also be promptly forwarded in a "Peer Review Privileged and Confidential" and sealed envelope to the Chairperson of the Quality Council, the Medical Staff Peer Review Committee and the Credentials Committee.

ARTICLE 4 - PART E: PROVISIONS COMMON TO ALL MEETINGS

Section 1 Notice of Meetings:

Notice of all meetings of the Medical Staff and regular meetings of departments and committees shall be distributed by email to the designated Members at least five (5) days in advance of such meetings. This notice shall be deemed to constitute actual notice of the persons concerned. All Active Staff Appointees are encouraged to attend meetings of the Medical Staff, their assigned department, and assigned committees.

Section 2 Rules of Order:

The currently revised Robert's Rules of Order shall govern the conduct of all meetings and elections of the Medical Staff. Whenever Robert's Rules of Order conflict with these Bylaws, the Bylaws shall govern.

Section 3 Voting:

Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one (1) vote.

ARTICLE 5
DEPARTMENTS

ARTICLE 5 - PART A: DEPARTMENTS

Section 1 List of Departments:

The following departments are established. Additional departments or divisions of departments, as required from time to time, may be established by the Board after considering recommendations from the Executive Committee.

a) Medicine:
- Emergency Services
- Family Practice
- Internal Medicine and Sub-specialties
- Pediatrics/Nursery
- Psychiatry
- Radiology

b) Surgery:
- Anesthesia
- Obstetrics/Gynecology
- Pathology
- Surgery and Sub-specialties

Section 2 Functions of Departments:

a) Each department shall recommend to the Credentials Committee written criteria for the assignment of Clinical Privileges within the department and each of its divisions. Such criteria shall be consistent with and subject to all Applicable Requirements and the Bylaws, policies, Rules and Regulations of the Medical Staff and the Hospital. These criteria shall be effective when approved by the Board. Clinical Privileges shall be based upon demonstrated training and experience within the specialty covered by the department.

b) Pursuant to Article 4(D), each department or clinical service within each department shall monitor and evaluate medical care on a retrospective, concurrent and prospective basis, and shall select cases for presentation at its meetings that will contribute to the continuing education of the members of the department or service. Such presentation should include cases involving deaths or complications, quality assessment clinical monitors, and such other cases believed to be important, such as those involving patients currently in the Hospital with unsolved clinical problems.

c) Pursuant to Article 4(D), a copy of all minutes shall be promptly forwarded to the President and the Chief Executive Officer. In the case of any special "Peer Review Committee" session, a copy of the minutes shall also be promptly forwarded in a stamped "Peer Review Privileged and Confidential" sealed envelope to the Chairperson of the Quality Council, the Chairperson of the Medical Staff Peer

Review Committee and the Chairperson of the Credentials Committee. Additionally, the department chairperson may call for and conduct a Collegial Intervention involving the subject Practitioner.

d) All decisions concerning functions and responsibilities of its department members, including but not limited to, call schedules, care for unassigned patients, emergency service call, consultations, and teaching assignments, shall be addressed at the department level, subject to the required approvals of the Executive Committee and/or the Board.

Section 3 Department Chairpersons:

a) The chairperson of each department shall be an Appointee to the Active Staff in Good Standing, without restriction, who is qualified by training, board certification, experience and administrative ability for the position. In the event an Appointee is not board certified, the credentialing and privileging process should demonstrate comparable competence.

b) The chairperson of each department (i.e., Medicine and Surgery) shall be appointed by the President, subject to approval by the Board. The Board shall not withhold approval of the Medical Staff department chairpersons without reasonable cause.

c) Initial appointment of a chairperson shall be made for a period of one (1) year. Reappointment by the President may be made yearly thereafter, again subject to approval by the Board. Chief(s) of the various services within each department shall be appointed by the President, after receiving the recommendation of the chairperson, and subject to approval by the Board. A chief's tenure shall coincide with that of such chief's chairperson.

d) A chairperson may be removed from office by either the department of the Medical Staff or the Executive Committee, and the Board for failure to perform the obligations and responsibilities of the particular office as required by the Medical Staff Bylaws and other policies, procedures and resolutions of the Medical Staff, Board, and the Hospital.

e) A chairperson may be removed from office by the department of the Medical Staff as a result of a petition of at least twenty-five percent (25%) of the Active Medical Staff Members in Good Standing in the particular department, and at least a two-thirds (2/3) majority vote of the Active Medical Staff Members in Good Standing in the particular department who are present to vote during a regular or special meeting of the department called for such purpose by the Executive Committee. The chairperson in question shall not be present during the department meeting. No such removal by the Members of the department shall be effective unless and until the action has been approved by the Executive Committee and/or the Board.

f) A chairperson may also be removed from office by a two-thirds (2/3) majority vote of the Executive Committee. The chairperson in question shall not be present

during the vote. No such removal by the Executive Committee shall be effective unless and until the action has been approved by the Board.

Section 4 Functions of Department Chairpersons:

Each chairperson shall:

a) Be accountable for clinically related activities and professional and administrative activities within the department;

b) Be a member of the Executive Committee;

c) Maintain continuing surveillance of the professional performance of all individuals who have delineated Clinical Privileges in the service, and report and recommend thereon to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;

d) Recommend criteria for Clinical Privileges that are relevant to the care provided in the department/service;

e) Recommend Clinical Privileges for each member of the department;

f) Monitor and evaluate the quality and appropriateness of patient care provided within the service;

g) Be responsible for enforcement within the department of the Hospital policies and procedures, and the Medical Staff Bylaws and Rules and Regulations;

h) Be responsible for implementation within the department of actions taken by the Board and the Executive Committee;

i) Submit written findings to the Credentials Committee concerning the appointment, reappointment, and delineation of Clinical Privileges for all Applicants seeking privileges in the department;

j) Be responsible for the establishment, implementation and effectiveness of any teaching, education and research programs in the department;

k) Report and recommend to the Hospital Management when necessary with respect to matters affecting patient care in the department, including personnel, supplies, special regulations, standing orders and techniques;

l) Assist the Hospital Management in the preparation of annual reports and such budget planning pertaining to the department as may be required by the Chief Executive Officer or the Board;

m) Delegate to chief(s) of service(s) within the department such duties as such chairperson deems appropriate;

n) Assess and recommend to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization;

o) Call for and conduct Collegial Interventions involving individual Practitioners;

p) Assist with orientation and continuing education of all persons in the department or service;

q) Recommend space and other resources needed by the department or service;

r) Integrate the department or service into the primary functions of the Hospital;

s) Coordinate and integrate interdepartmental and intradepartmental services;

t) Recommend a sufficient number of qualified and competent persons to provide care, treatment, and services;

u) Determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

v) Continuous assessment and improvement of the quality of care, treatment, and services; and

w) Maintain quality control programs, as appropriate.

Section 5 Department of Surgery - Operating Room Committee:

The Department of Surgery shall establish an Operating Room Committee which shall:

a) Be comprised of the Chief of Surgery (who serves as the chairperson of the Operating Room Committee), Chief of Anesthesia, the immediate past Chief of Surgery, the Medical Director of Trauma Services, a representative from the Department of Surgery who is elected by the Department of Surgery, the Director of Surgical Services (Nursing), and the Vice President of Patient Services or designee. Should the immediate past Chief of Surgery or the Department of Surgery representative become unable to serve, the Department of Surgery will elect a replacement;

b) Meet at least six (6) times per year at a time set by the chairperson;

c) Review, monitor and revise the operating room rules and regulations and policies and procedures, including but not limited to, reviewing utilization statistics, reviewing the block allocation of operating rooms, supporting the implementation of changes to the scheduling system as needed, supporting a computerized scheduling system, establishing productive staffing policies and monitoring Practitioner behavior;

d) Provide input into establishing goals for the Department of Surgery;

e) Review other issues affecting the Department of Surgery such as laboratory services, infection control, emergency procedures, etc.;

f) Provide input into the Hospital's budget and shall assist in prioritizing surgically related budget requests;

g) Notify the chairperson of the Department of Surgery, in writing, of any facts or circumstances that may require the review of the competence or professional conduct of an individual Practitioner, a Collegial Intervention, or other remedial or Corrective Action; and

h) Have the authority to make binding decisions for the Department.

ARTICLE 6
COMMITTEES OF THE MEDICAL STAFF

ARTICLE 6 - PART A: COMMITTEES

Section 1 Chairperson:

a) The chairperson of each committee shall be an Appointee to the Active Staff who is qualified by training, experience and administrative ability for the position.

b) All committee chairpersons, unless otherwise provided for in these Bylaws, shall be appointed by the President, subject to approval by the Board. The Board shall not withhold approval of the Medical Staff committee chairpersons without reasonable cause.

c) Initial appointment of a committee chairperson shall be made for a period of one (1) year. Reappointment by the President may be made yearly thereafter, again subject to approval by the Board.

d) A chairperson may be removed from office by a two-thirds (2/3) majority vote of the Executive Committee. The chairperson in question shall not be present during the vote. No such removal by the Executive Committee shall be effective unless and until the action has been approved by the Board.

Section 2 Members:

a) Members of each committee, except as otherwise provided for in these Bylaws, shall be appointed yearly by the President, not more than ten (10) days after the end of the Medical Staff year, with no limitation in the number of terms they may serve. All appointed members may be removed and vacancies filled by the President at the President's discretion.

b) The Chief Executive Officer and the President or their respective designees shall be members, ex-officio without vote, on all committees, unless stated otherwise.

Section 3 Meetings:

Unless otherwise specified in these Bylaws, each committee shall meet at least quarterly. Each committee's chairperson shall, in cooperation with the committee members, determine the day and time for regular meetings. A quorum for doing business shall be one-fourth (1/4) of the voting members of such committees, unless these Bylaws specifically state otherwise.

ARTICLE 6 - PART B: EXECUTIVE COMMITTEE

Section 1 Composition:

a) The Executive Committee membership shall consist of the officers of the Medical Staff (President, Vice-President and Secretary-Treasurer), the Chairpersons of each

of the two departments (i.e., Medicine and Surgery), and the Chairpersons of the following committees:

1) Surgical Quality Assessment/Performance Improvement Committee;

2) Pharmacy & Therapeutics/Infection Prevention and Control Committee; and

3) Utilization Review/Medical Records Committee

The Chairperson of the Credentials Committee shall be a member of the Executive Committee, ex-officio, without vote, on any and all matters that were originally before the Credentials Committee for which the Chairperson voted.

b) The President shall be Chairperson of the Executive Committee.

c) The Chief Executive Officer, the Vice President of Patient Services, the Chief Medical Officer, and the Chairperson of the Board may attend meetings of the Executive Committee and participate in its discussions, but without vote.

Section 2 Duties:

The duties of the Executive Committee shall be:

a) Represent and to act on behalf of the Medical Staff in all matters, without requirement of subsequent approval by the staff, between meetings of the Medical Staff, subject only to any limitations imposed by these Bylaws;

b) Coordinate the activities and general policies of the various departments;

c) Receive and act upon committee and department reports, including Credentials Committee reports, and to make recommendations concerning them to the Chief Executive Officer and the Board, as well as to the committees and/or departments, subject to Article 4(D);

d) Implement policies of the Medical Staff that are not the responsibility of the departments;

e) Provide liaison among the Medical Staff, the Chief Executive Officer and the Board;

f) Keep the Medical Staff abreast of applicable accreditation and regulatory requirements affecting the Hospital;

g) Enforce Hospital and Medical Staff rules in the best interest of patient care and of the Hospital on the part of all persons who hold appointment to the Medical Staff;

h) Direct any minutes, reports or other communications from departments, committees or other third parties to the Credentials Committee that question the competence or professional conduct of a Medical Staff Appointee and which merit further investigation or other action by the Credentials Committee pursuant to Article 4(D);

i) Direct an officer or chairperson or a particular department or committee to conduct a Collegial Intervention involving an individual Practitioner;

j) Request evaluations of Practitioners privileged through the Medical Staff process in instances where there is doubt about an Applicant's ability to perform the Clinical Privileges requested;

k) Be responsible to the Board for the implementation of the Hospital's Quality Assessment/Performance Improvement Plan as it affects the Medical Staff; and

l) Review the Bylaws, the Rules and Regulations of the Medical Staff, and associated documents at least once every three (3) years and recommend such changes thereto as may be necessary or desirable, through the established amendment process described in Article 11.

Section 3 Meetings, Reports and Recommendations:

The Executive Committee shall meet at least once each month or more often if necessary to transact pending business. Reports with any recommendations of the Executive Committee shall be transmitted to the Board with a copy to the Chief Executive Office, subject to Article 4(D). The President, in addition to any department or committee chairperson(s) as may be necessary, shall be available to meet with the Board or its applicable committee regarding all Executive Committee reports and related recommendations. Between meetings of the Executive Committee, an ad hoc committee composed of at least two (2) Medical Staff officers and the chairperson of the Credentials Committee shall be empowered to act in situations of urgent or confidential concern where not prohibited by these Bylaws.

ARTICLE 6 - PART C: CREDENTIALS COMMITTEE

Section 1 Composition:

a) The Credentials Committee membership shall consist of the three (3) most recent past presidents who are still Appointees of the Active Staff. The chairperson shall be the past president member of the committee with the greatest seniority. The chairperson shall then appoint at least two (2) but no more than six (6) additional Active Staff Appointees who shall serve as at-large members of the committee for terms of one (1) year. Service on this committee shall be considered the primary Medical Staff obligation of each member of the committee and other Medical Staff duties shall not interfere.

b) The Chief Executive Officer, the Chief Medical Officer, the Director of Quality Services, and the Chairperson of the Board may attend meetings of the Credentials Committee and participate in its discussions, but without vote.

Section 2 Duties:

The duties of the Credentials Committee shall be:

a) Review and investigate the credentials of all Applicants or Appointees for Medical Staff appointment, reappointment, and Clinical Privileges for the Executive Committee; interview such Applicants and Appointees as may be necessary; and to make recommendations on the same in accordance with Article 4(D), 7 and 8 of these Bylaws;

b) Review and investigate facts and circumstances that may question the competence or professional conduct of an individual Practitioner and as a result of such review to make recommendations on the same in accordance with Articles 4(D) and 8 of these Bylaws.

Section 3 Meetings, Reports and Recommendations:

The Credentials Committee shall meet as often as necessary to accomplish its duties, but at least six (6) times a year and shall maintain a permanent record of its proceedings and actions. Reports with any recommendations of the Credentials Committee shall be transmitted to the Board with a copy to the Executive Committee and the Chief Executive Officer, subject to Article 4(D). The chairperson, in addition to any committee members as may be necessary, shall be available to meet with the Board or its applicable committees on all Credentials Committee reports and related recommendations. Between meetings of the Credentials Committee, an ad hoc committee composed of the chairperson and at least two (2) members shall be empowered to act in situations of urgent or confidential concern where not prohibited by the Bylaws.

ARTICLE 6 - PART D: UTILIZATION REVIEW/MEDICAL RECORDS COMMITTEE

Section 1 Composition:

a) The Utilization Review/Medical Records Committee membership shall consist of at least four (4) Active Staff Appointees representing each department (i.e., Medicine and Surgery), the Director of Quality Services of the Hospital, the Chief Medical Officer, and a representative of Hospital Administration (e.g., Chief Executive Officer or designee).

b) The Chief Executive Officer shall also assign a Hospital representative from medical records, utilization review, and patient services to the committee.

c) Additionally, this Committee Chairperson may, at the Chairperson's discretion, assign a representative from social service, home care, or other services of the Hospital to this Committee to assist it in its functions. If necessary, the Chairperson

may request monthly reports from those individuals or Hospital departments which are necessary for the usual functions of this Committee.

Section 2 Duties:

The duties of the Utilization Review/Medical Records Committee shall be:

a) Medical Care Evaluation Studies:

1) Conduct an ongoing analysis of the quality of clinical practice and patient care in all Medical Staff services and review the findings and results of departments, committees and other staff activities designed to monitor clinical practices and patient care, pursuant to Article 4(D) of these Bylaws.

b) Utilization Review Functions:

1) Conduct utilization review monitoring designed to evaluate over-utilization, under-utilization, and the efficient use of the Hospital's resources pursuant to Article 4(D) of these Bylaws.

2) Formulate a written utilization review plan for the Hospital, to be approved by the Executive Committee, the Chief Executive Officer and the Board. Such plan shall at least be in accordance with all applicable accreditation, regulatory and third-party payer requirements.

3) Evaluate the medical necessity for continued Hospital services for particular patients, where appropriate, and make recommendations on the same to the attending Physician, the Executive Committee and the Chief Executive Officer pursuant to Article 4(D) of these Bylaws. No Physician shall have review responsibility for any extended stay cases in which such Physician was professionally involved.

c) Medical Records Functions:

1) Determine that each medical record, or a representative sample of records, reflects the diagnosis, admission and continued stay criteria, professional services furnished, prescribed drugs and biologicals, results of diagnostic tests, therapy rendered, condition and in-Hospital progress of the patient, and condition of the patient at discharge.

2) Conduct periodic reviews of summary information regarding the timely completion and adequacy of all medical records.

3) In the case of History and Physical Examinations and Reports ("H&P Reports"), the committee shall be responsible for confirming Medical Staff compliance with the requirements set out in the Rules and Regulations, Article XII (Medical Records), which requires all such History and Physical Examinations and Reports to be completed by a Physician, Advanced

Practice Nurse or Physician Assistant, as authorized by applicable Clinical Privileges, within twenty-four (24) hours of the patient's admission to the Hospital. Failure to comply will render the medical record incomplete and delinquent. Any such H&P Reports completed by an Advance Practice Nurse or Physician Assistant, who does not otherwise have admitting privileges, shall require the co-signature of the collaborating or supervising Physician, as appropriate, within the twenty-four (24) hour window.

Section 3 Completion of History and Physical Examinations:

a) The medical history and physical examination shall be completed within twenty-four (24) hours of the patient's admission or the chart will be considered delinquent. The H&P Report must be completed by a Physician, oral/maxillofacial surgeon, dentist, podiatrist, Advance Practice Nurse ("APRN"), or Physician Assistant credentialed to do so. When the H&P Report is completed by an APRN or Physician Assistant, it must be co-signed by the supervising Physician for the Physician Assistant or by the Physician with whom the APRN has a collaborative practice agreement, unless the APRN has admitting privileges. Students and residents in appropriate training programs may perform the history and physical examination if preceptored and countersigned by a Practitioner on the Medical Staff.

b) The medical history and physical examination shall include all pertinent history and findings resulting from an assessment of all the systems of the body. At a minimum, the history and physical must include the details/history of present illness, past medical history, pertinent social and family history, review of systems, relevant physical examination, conclusion/impression, course of action and any pertinent immunizations (particularly for pediatric patients).

c) If a complete history and physical examination has been performed and made a part of the medical record up to thirty (30) days prior to the patient's admission or registration to the Hospital, a reasonably durable, legible copy of this H&P Report may be used in the patient's Hospital medical record in lieu of a newly recorded admission history and physical examination, provided this H&P Report was recorded by a member of the Medical Staff. In such instances, an addendum to the history and physical must be completed within twenty-four (24) hours of admission or registration, but prior to surgery or a procedure requiring anesthesia services. The update note must document an examination for any changes in the patient's condition since the time that the history and physical was performed that might be significant for the planned course of treatment. If a complete history and physical examination has been performed and made part of the medical record greater than thirty (30) days prior to the patient's admission to the Hospital, a new complete history and physical must be completed.

Section 4 Meetings, Reports and Recommendations:

The Utilization Review/Medical Records Committee shall meet a minimum of four (4) times per year and shall make a report thereof after each meeting to the Executive Committee and the Chief Executive Officer, subject to Article 4(D).

ARTICLE 6 - PART E: SURGICAL QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT COMMITTEE

Section 1 Composition:

a) The Surgical Quality Assessment/Performance Improvement Committee membership shall consist of five (5) Active Staff Appointees (specifically, two (2) surgeons, one (1) physician from the Department of Medicine, one (1) anesthesiologist, and one (1) pathologist), the Director of Quality Services of the Hospital, a representative of Patient Services (Nursing), and a representative of the Laboratory/Blood Bank.

b) Additionally, the Committee Chairperson may, at such Chairperson's discretion, assign a representative from other services of the Hospital to this Committee to assist it in its functions. If necessary, the Chairperson may request monthly reports from those individuals or Hospital departments which are necessary for the usual functions of this Committee.

Section 2 Duties:

The duties of the Surgical Quality Assessment/Performance Improvement Committee shall be:

a) Procedure Review:

1) Conduct a comprehensive review of operative and other procedures which place patients at risk, based on review criteria as established by the Committee and maintain written reports reflecting the results of all evaluations performed and actions taken, subject to Article 4(D) of these Bylaws.

2) Review and discuss cases and situations which do not meet the criteria of care established by the department, subject to Article 4(D).

b) Blood Utilization Review Functions:

1) Review blood transfusions for proper utilization. Each actual or suspected transfusion reaction shall be evaluated and a report completed. The evaluation of blood use should include a review of the amount of blood requested, the amount used, and the amount of wastage.

Section 3 Meetings, Reports and Recommendations:

The Surgical Quality Assessment/Performance Improvement Committee shall meet at least quarterly and shall make a report thereof after each meeting to the Executive Committee and the Chief Executive Officer, subject to Article 4(D).

ARTICLE 6 - PART F: MEDICINE QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT COMMITTEE

Section 1 Composition:

a) The Medicine Quality Assessment/Performance Improvement Committee membership shall consist of the Chairperson of the Department of Medicine (who shall serve as the Chairperson of this committee), the Chief of Family Practice, the Chief of Internal Medicine, the Chairperson of the Critical Care Services Committee, the Chief of Emergency Medicine, the Chief of Pediatrics/Nursery, and the Director of Quality Services of the Hospital.

b) Additionally, this Committee Chairperson may, at such Chairperson's discretion, assign a representative from other services of the Hospital to this Committee to assist it in its functions. If necessary, the Chairperson may request monthly reports from those individuals or Hospital departments which are necessary for the usual functions of this Committee.

Section 2 Duties:

The duties of the Medicine Quality Assessment/Performance Improvement Committee shall be:

a) Review reports from the service areas of the department;

b) Review and discuss cases and situations which do not meet the criteria of care established by the Department, subject to Article 4(D); and

c) Review all mortalities and morbidities as deemed appropriate.

Section 3 Meetings, Reports and Recommendations:

The Medicine Quality Assessment/Performance Improvement Committee shall meet at least quarterly and shall make reports to the Quality Council and to the Medical Staff Peer Review Committee, subject to Article 4(D).

ARTICLE 6 - PART G: PHARMACY AND THERAPEUTICS/INFECTION PREVENTION AND CONTROL COMMITTEE

Section 1 Composition:

a) The Pharmacy and Therapeutics/Infection Prevention and Control Committee membership shall consist of four (4) Active Staff Appointees representing each department (i.e. Medicine and Surgery), the Director of Quality Services of the Hospital, the Infection Prevention Nurse of the Hospital, a representative of Pharmacy, a representative of Employee Health, a representative of Sterile Processing, a representative of Environmental Services, a representative of Patient Services (Nursing), a representative of the Laboratory, the Chief Medical Officer, and a representative of Hospital administration (i.e., Chief Executive Officer or designee).

b) Additionally, this Committee Chairperson may, at such Chairperson's discretion, assign a representative from other services of the Hospital to this Committee to assist it in its functions. If necessary, the Chairperson may request monthly reports from those individuals or Hospital departments which are necessary for the usual functions of this Committee.

Section 2 Duties:

The duties of the Pharmacy and Therapeutics/Infection Prevention and Control Committee shall be:

a) Pharmacy/Therapeutics Functions:

1) Review the appropriateness of prophylactic, empiric and therapeutic use of drugs through the analysis of individual or aggregate patterns of drug practice;

2) Develop and recommend to the Executive Committee and the Board procedures relating to the selection, distribution, handling, use and administration of drugs and diagnostic testing materials;

3) Review all significant untoward drug reactions, subject to Article 4(D);

4) Maintain a formulary or drug list, to be updated at least annually, subject to the Executive Committee and the Board approval;

5) Evaluate and, if appropriate, approve research protocols concerned with the use of investigational or experimental drugs, in addition to new uses of approved drugs, as part of clinical trials; and

6) Review the appropriateness, safety, and effectiveness of the prophylactic, empiric and therapeutic use of antibiotics in the Hospital.

b) Infection Prevention and Control Functions:

1) The committee shall be responsible for the surveillance of inadvertent Hospital infection potentials;

2) The committee shall conduct a regular review and analysis of actual infections;

3) The committee shall promote a preventive and corrective program designed to minimize infection hazards; and

4) The committee shall supervise infection control in all phases of the Hospital's activities.

Section 3 Meetings, Reports and Recommendations:

The Pharmacy and Therapeutics/Infection Prevention and Control Committee shall meet at least every other month and shall make a report thereof after each meeting to the Executive Committee and the Chief Executive Officer, subject to Article 4(D) of these Bylaws.

ARTICLE 6 - PART H: CANCER COMMITTEE

Section 1 Composition:

a) The Cancer Committee's responsibility for program leadership is multi-disciplinary and represents the full scope of care provided at the Hospital. The Cancer Committee membership includes board certified Physicians from all medical specialties involved in the care of patients with cancer, and shall consist of at least one (1) Medical Staff Appointee from each of the following specialty areas: diagnostic radiology, pathology, general surgery, medical oncology, and radiation oncology. (If all radiation oncology services are provided by referral and the facility's medical staff does not include a radiation oncologist, then a Cancer Committee member from radiation oncology is recommended, but not required.) The American College of Surgeons Field Liaison Physician will also serve on the Cancer Committee.

b) Additionally, the Cancer Committee also includes representatives from the following areas: cancer program administrator, oncology nurse, social worker or care manager, Certified Tumor Registrar (CTR), and the performance improvement or quality management professional, who shall be appointed by the Chief Executive Officer.

c) The membership of the Cancer Committee is evaluated annually.

Section 2 Duties:

The duties of the Cancer Committee shall be:

a) Responsible for planning, initiating, stimulating and assessing all cancer-related activities in the Hospital. The main goal of the Cancer Committee is to decrease the morbidity and mortality of cancer within our community;

b) Assures the leadership for an effective cancer program and the success is dependent on an effective Cancer Committee;

c) Monitors the multi-disciplinary membership attendance;

d) Promotes team involvement and shared responsibilities through assigning designated coordinators for 1) Tumor Board, 2) Quality Control of the Cancer Registry Data, 3) Quality Improvement, and 4) Community Outreach;

e) Develops and evaluates annual goals and objectives for clinical, outreach, quality improvement and programmatic endeavors related to cancer care;

f) Establishes the Tumor Board multi-disciplinary attendance, frequency, and program format annually;

g) Ensures that the required number of cases are discussed at Tumor Board;

h) Monitors and evaluates the Tumor Board total case presentation and prospective case presentation annually;

i) Establishes and implements a plan to evaluate the quality of cancer registry data and activity on an annual basis;

j) Analyzes patient outcomes and disseminates the results of the analysis on an annual basis;

k) Monitors the percentage of cases including American Joint Commission on Cancer Staging on all eligible cases; and

l) Monitors the inclusion of College of American Pathologists Protocols on all eligible pathology reports.

Section 3 Meetings, Reports and Recommendations:

a) The Cancer Committee shall meet at least quarterly and shall make a report thereof after each meeting to the Executive Committee and the Chief Executive Officer, subject to Article 4(D) of these Bylaws. The committee will follow all cancer program recommendations of the American College of Surgeons, Commission on Cancer.

b) The Cancer Committee may recommend dissolution by a majority vote of those present (a quorum must be present to vote). This recommendation must be approved by the Executive Committee and shall become effective only when approved by the Board.

ARTICLE 6 - PART I: MEDICAL STAFF PEER REVIEW COMMITTEE

Section 1 Composition:

a) The Medical Staff Peer Review Committee membership shall consist of the officers of the Medical Staff (President, Vice President, and Secretary-Treasurer), the chairpersons of each of the two (2) departments (Medicine and Surgery), the chairpersons of the Surgical Quality Assessment/Performance Improvement Committee, the Pharmacy and Therapeutics/Infection Prevention and Control Committee, the Utilization Review/Medical Record Committee and the Credentials Committee. The Peer Review Committee is composed of at least fifty percent (50%) of individual professional health care providers (as defined in I.C. §34-6-2-117), one of whom shall serve as the chairperson of this committee.

Section 2 Duties:

The duties of the Medical Staff Peer Review Committee shall be:

a) Provide Physician input to the peer review process, including review and discussion of cases and situations which do not meet the criteria of care or service, which have been established by the various Medical Staff departments, services, and/or committees, subject to Article 4(D);

b) Receive and review variance reports and other similar reports and documents which represent serious and/or significant discrepancies from established criteria, and which are being addressed by a department, service, or committee of the Medical Staff for further review and/or action, subject to Article 4(D);

c) Investigate and evaluate the merits of a complaint against a subject Physician that includes a determination or recommendation concerning the complaint, and the complaint is based on the competence or professional conduct of the subject Physician, whose competence or conduct affects or could Adversely Affect the health or welfare of a patient or patients; and

d) Take action upon or make recommendations regarding any discrepancies from care or service, subject to Article 4(D).

Section 3 Meetings, Reports and Recommendations:

The Medical Staff Peer Review Committee shall meet twice annually, or more often as required, and shall make a report thereof after each meeting to the Executive Committee and the Chief Executive Officer, subject to Article 4(D) of these Bylaws. A quorum for taking action or making a recommendation shall be one-half (1/2) of the members of the committee.

ARTICLE 6 - PART J: BYLAWS COMMITTEE

Section 1 Composition:

a) The Bylaws Committee should include Active Staff Appointees from a variety of medical specialties and age groups. There should be at least five (5) Physician members of the committee.

b) The Chief Executive Officer, the Chief Medical Officer, the Director of Quality Services, and the Chairperson of the Board may attend meetings of the Bylaws Committee and participate in its discussions, but without vote.

Section 2 Duties:

All reviews and recommendations carried out by the Bylaws Committee shall be in accordance with Articles 10, 11 and 12 of these Medical Staff Bylaws. The duties of the Bylaws Committee shall be:

a) Consider and discuss any proposed amendments to and/or revisions of the Medical Staff Bylaws referred by the Executive Committee;

b) Consider and discuss any proposed amendments to and/or revisions of the Medical Staff Rules and Regulations referred by the Executive Committee, by a Department, by other Medical Staff committees, or from a Medical Staff meeting;

c) Review the Medical Staff Bylaws document at least every three (3) years, or more often if the need arises;

d) Review the Medical Staff Rules and Regulations document at least every three (3) years, or more often if the need arises; and

e) Consider and discuss any other business or concerns related to the Medical Staff Bylaws and/or Rules and Regulations, as deemed necessary by the Chairperson of the Bylaws Committee.

Section 3 Meetings, Reports and Recommendations:

The Bylaws Committee shall meet at least once every three (3) years or more often as needed. Meetings of the Bylaws Committee are called by the Chairperson as needed to carry out the above duties. The Bylaws Committee shall make a report thereof after each meeting to the Executive Committee and the Chief Executive Officer.

ARTICLE 6 - PART K: CRITICAL CARE SERVICES COMMITTEE

Section 1 Composition:

a) The membership of the Critical Care Services Committee shall consist of at least five (5) Active Staff Appointees including two (2) Department of Medicine

physicians, one (1) emergency services physician, one (1) anesthesiologist, one (1) cardiologist, the Nursing Director of Critical Care Services of the Hospital, the Nursing Director of Surgical Services of the Hospital, the Nursing Director of Emergency Services of the Hospital, a pharmacist, the Chief Medical Officer, and the Medical Director of Trauma Services, who shall serve, at all times, as one (1) of the two (2) Co-Chairpersons of the Committee. The Medical Director of Trauma Services shall also serve, at all times, as Co-Medical Director of the Critical Care Services Department.

b) The Chairperson of the Department of Medicine and a representative of Hospital administration (e.g., Chief Executive Officer or designee) shall be members of the Critical Care Services Committee, ex-officio, without vote.

c) Additionally, this Committee Co-Chairpersons may, at such Co-Chairpersons' discretion, assign a representative from other services of the Hospital to this Committee to assist in its functions. If necessary, the Co-Chairpersons may request monthly reports from those individuals or Hospital departments which are necessary for the usual functions of this Committee.

Section 2 Duties:

The duties of the Critical Care Services Committee shall be:

a) Quality Assessment/Performance Improvement review includes:

1. Reviews all Code Blue cases;

2. Reviews and discusses cases and situations which do not meet the criteria of care established by the Critical Care Services;

3. Reviews nursing quality assessment/performance improvement data; and

4. Reviews national data and comparison data which is available (i.e., Indiana Hospital and Health Association data).

b) Critical Care Services Procedure review includes:

1) Reviews of medications and other protocols utilized within the Critical Care Services Department.

c) Co-Chairpersons' responsibilities:

1) Serve as the Co-Medical Directors of the Critical Care Services Department;

2) Assist with bed allocation when necessary;

3) Assist with planning and selection of new equipment purchases; and

4) Monitor and evaluate the quality and appropriateness of patient care provided within the Critical Care Services Department and may initiate a consultation or intervene as appropriate or necessary.

Section 3 Meetings, Reports and Recommendations:

The Critical Care Services Committee shall meet at least six (6) times per year, and shall maintain a permanent record of its findings, proceedings, and actions.

ARTICLE 6 - PART L: PRACTITIONER ASSISTANCE COMMITTEE

Section 1 Composition:

The Practitioner Assistance Committee shall be composed of the officers of the Medical Staff and the Chief Medical Officer.

Section 2 Duties:

The duties of the Practitioner Assistance Committee shall be:

a) Educate Hospital and Medical Staff representatives regarding the prevention, detection and early intervention in the case of Impaired Practitioners and the various signs and symptoms that may aid in the early intervention and treatment of an Impaired Practitioner, including but not limited to the following:

1) Behavioral signs such as mood changes, depression, slowness, lapses of attention, chronic exhaustion, risk taking behavior, excessive cheerfulness, flat affect;

2) Signs of inappropriate use/abuse of any mind-altering substances, including but not limited to excessive agitation or edginess, dilated or pinpoint pupils, alcohol on breath, slurred speech, inappropriate conduct;

3) Physical signs of fatigue, significant weight loss, deterioration in personal hygiene and appearance, multiple physical complaints, accidents, disruptive or altered eating patterns;

4) Disturbance in family stability or evidence of personal or professional relationship difficulties resulting in isolation;

5) Social changes such as withdrawal from outside activities, isolation from peers, embarrassing or inappropriate behavior, adverse interactions with law enforcement, driving while intoxicated, or other undependable, argumentative, unpredictable or aggressive behavior;

6) Unexplained patterns of professional behavior or changes in work habits involving absences, tardiness, decreasing quality or interest in work,

inappropriate orders, altered interactions with the Hospital and Medical Staff; and

7) Other conduct in violation of the Hospital's Code of Conduct or other such conduct which a reasonable person would find offensive, hostile, intimidating, disruptive or that would cause a reasonable person to fear for his or her personal safety or that of other persons or property on the Hospital premises.

b) Receive and review reports from any source, anonymous or otherwise, who have reason to believe that an individual Practitioner may be impaired or otherwise qualify as an Impaired Practitioner under these Bylaws;

c) Conduct further investigation of any such reports, including but not limited to arranging for Collegial Intervention, physical/mental examinations, drug testing or other steps necessary to confirm whether an individual Practitioner qualifies as an Impaired Practitioner;

d) Act as a liaison between the Practitioner Assistance Committee and the applicable state or local professional association (e.g., Indiana State Medical Association's Physician Assistance Program) that may be helpful in conducting an intervention or to otherwise assist an individual Impaired Practitioner to secure the necessary evaluation, treatment, monitoring or other assistance necessary;

e) Provide continuous monitoring of Impaired Practitioners so to assure compliance with all treatment requirements in addition to any and all state or local professional association and/or Licensing Board requirements;

f) Identify those Impaired Practitioners who have successfully completed all treatment requirements in addition to any and all state or local professional association and/or Licensing Board requirements, and to terminate continuous monitoring arrangements by the Practitioner Assistance Committee, as appropriate;

g) Report to the President regarding any Impaired Practitioners who have failed to progress or otherwise comply with all treatment requirements or any and all state or local professional association or Licensing Board requirements for the purpose of initiating Corrective Action under Article 8(C)(2) of these Bylaws; and

h) Comply with Applicable Requirements that may require other reports to the appropriate Licensing Board in the event an Impaired Practitioner fails to progress or to otherwise comply with treatment requirements or other state or local professional association or Licensing Board requirements, but only upon the advice of designated legal counsel.

Section 3 Meetings, Reports, and Recommendations:

The Practitioner Assistance Committee shall meet when necessary. Reports and any related recommendations of the Practitioner Assistance Committee shall be designated and kept

confidential, maintained in a confidential file in the Medical Staff Office, and submitted to the President and the Chairperson of the Credentials Committee, with a copy to the Chief Executive Officer, pursuant to Article 4(D) of these Bylaws. In accordance with Applicable Requirements, the Chairperson of the Practitioner Assistance Committee, in conjunction with the President, may also be required to submit other reports to the appropriate state or local professional association or Licensing Board upon the advice of designated counsel.

ARTICLE 6 - PART M: MEDICAL STAFF REPRESENTATION ON OTHER COMMITTEES

There will be Medical Staff representation on at least the following Hospital committees: Safety/Risk Management Committee, the Special Care Units Committees, and the Quality Council.

ARTICLE 6 - PART N: CREATION OF STANDING COMMITTEES

The Executive Committee may by resolution and upon approval of the Board, without amendment of these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the Executive Committee may by resolution and upon approval by the Board, dissolve or rearrange committee structure, duties or composition as needed, to better perform the Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to a standing or special committee shall be performed by the Executive Committee.

ARTICLE 6 - PART O: SPECIAL COMMITTEES

Special committees shall be created and their members and chairperson shall be appointed by the President with the approval of the Board as required. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Executive Committee.

ARTICLE 7:
APPOINTMENT & REAPPOINTMENT TO THE MEDICAL STAFF

ARTICLE 7 - PART A: QUALIFICATIONS FOR APPOINTMENT & REAPPOINTMENT

Section 1 General:

Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in these Bylaws and in such policies as are adopted from time to time by the Board. All individuals practicing medicine, dentistry, podiatry, and oral surgery in this Hospital, unless exempted by specific provisions of these Bylaws, must first have been appointed to the Medical Staff. Requests will be handled in a manner outlined by the medical staff credentialing policy and procedure.

Section 2 Minimum Qualifications:

The minimum qualifications required of Physicians, dentists, podiatrists, and oral surgeons for appointment to the Medical Staff are as follows:

a) Completion and submission of a complete application, including:

b) Current licensure to practice medicine, dentistry, podiatry, or to perform oral surgery, as the case may be, in the State of Indiana, including Drug Enforcement Administration ("DEA") license and Controlled Substance Registration ("CSR") license (if applicable);

c) Education, training, experience and demonstrated competence;

c) Primary residence of each said Physician, dentist, podiatrist, or oral surgeon shall be located close enough to provide timely care for their patients, as appropriate or in accordance with Hospital policies and procedures;

d) Physician, dentist, podiatrist, and oral surgeon shall possess current, valid professional liability insurance coverage issued by a company licensed or approved by the State of Indiana, in such form and in amounts as required under I.C. §34-18-4-1 in order to qualify as a "health care provider."

e) Each Physician, dentist, podiatrist, or oral surgeon who submits an application on or after April 1, 2017, must be certified by a recognized board (as defined below) in the Applicant's primary specialty or subspecialty. The board certification requirements do not apply to Honorary staff members.

1) If the Applicant is not board certified as of the date of application, he/she may submit his/her application subject to the requirement that Applicant must obtain board certification within five (5) years from the date Applicant is eligible to sit for the board certification examination or within five (5)

years of the Applicant's date of initial appointment to the Medical Staff, whichever is earlier.

2) Once certified, the Appointee must remain board certified as a condition of Medical Staff membership. If the Medical Staff Member's board certification lapses for any reason, the Appointee will have a grace period of five (5) years to regain board certification. Board Certification requirements do not apply to current Members of the Medical Staff appointed prior to April 1, 2017. However, if a current Medical Staff Member is board certified as of April 1, 2017, he/she will be required to maintain board certification as noted in the paragraph above for reappointment.

3) Notwithstanding the requirement set forth above with respect to board certifications, it is acknowledged that a compelling patient care or community need may arise that necessitates consideration of an applicant to the Medical Staff who is not certified by a recognized board. In such circumstances, the Board, in the exercise of its discretion and upon the recommendation of the Executive Committee and/or Credentials Committee, may waive the requirement of board certification if such waiver is found by the Board to be essential to maintaining quality patient care.

4) A recognized board is a board recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the Royal College of Physicians and Surgeons of Canada, the American Board of Podiatric Surgery (AABPS), the American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM), the American Council of Certified Podiatric Physicians and Surgeons (ACCPPS), the American Board of General Dentistry, the American Board of Oral and Maxillofacial Surgery, or other boards approved by the Board.

5) The failure of a Medical Staff Member to comply with these requirements shall result in either the revocation of his/her Medical Staff membership or the denial of his/her application for reappointment, unless the requirement has been waived as noted in paragraph (3) above. Revocation of Medical Staff membership or denial of an application for reappointment for failure to comply with the applicable requirements of this section shall not be deemed an Adverse Action invoking a right to a hearing under the Hearing and Appeals Procedure of the Medical Staff Bylaws.

Section 3 No Entitlement to Appointment:

No Practitioner shall be entitled to appointment to the Medical Staff or to the exercise of particular Clinical Privileges in the Hospital merely by virtue of the fact that such Practitioner is licensed to practice any profession in Indiana or any other state; that such Practitioner is a member of any particular professional organization; that such Practitioner had in the past, or currently has, Medical Staff appointment or privileges in the Hospital or another hospital; or that such

Practitioner possesses current, valid professional liability insurance coverage pursuant to the Bylaws.

Section 4 Non-Discrimination Policy:

No Practitioner shall be denied appointment to the Medical Staff or granted or denied Clinical Privileges on the basis of gender, race, creed, color, age, religion, ancestry, disability or national origin, whether as the sole or partial reason for the denied appointment.

Section 5 Ethical and Religious Directives:

All Medical Staff Appointees and others exercising Clinical Privileges in the Hospital shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services ("Directives") promulgated by the National Conference of Catholic Bishops, and which may be amended from time to time. No activity prohibited by said Directives shall be engaged by any Medical Staff Appointee or other person exercising Clinical Privileges in the Hospital. These Directives are available for review and/or may be obtained from the Medical Staff Coordinator. A copy is given to each new Appointee to the Medical Staff.

ARTICLE 7: PART B: CONDITIONS OF APPOINTMENT & REAPPOINTMENT

Section 1 Duration of Initial Appointment:

All initial appointments to the Medical Staff regardless of the category of the Medical Staff to which the appointment is made and all initial Clinical Privileges shall be for a period of up to three (3) years following initial appointment. During the term of this initial appointment, the Practitioner shall be proctored and evaluated by the chairperson of the department(s) in which such Practitioner has Clinical Privileges, and by the relevant committees of the Medical Staff and the Hospital as to such Practitioner's competence and professional conduct. Clinical Privileges shall be adjusted to reflect clinical competence at the end of the initial appointment period or sooner if warranted. Continued appointment after the initial period shall be conditioned on an evaluation of the factors to be considered for reappointment set forth in Article 8, Part A, Section 2 of these Bylaws.

Section 2 Rights and Duties of Appointees:

Appointment to the Medical Staff shall confer on the Appointee only such Clinical Privileges as have been granted by the Board and shall require that each Appointee assume such reasonable duties and responsibilities as the Board and/or the Medical Staff shall require.

Section 3 Application Process:

The form, content and procedure for appointment and reappointment shall be prescribed in the medical staff credentials policy and procedure manual. In summary, applications for appointment to the Medical Staff and requests for Clinical Privileges shall be made to the Medical Staff Office, where certain items of information are verified and additional information is collected. Completed applications and supporting documents are reviewed by the Department

Chief, Credentials Committee and forwarded with either a positive or negative recommendation to the Executive Committee. The Executive Committee recommendations are then forwarded to the Board of Directors. Final decisions on applications are made by the applicable governing board.

The Credentials Committee shall make recommendations on all initial applications and reappointment for privileges, which are based upon assessment of the applicant's current competence as documented by:

Education;

Training;

Experience;

Licensure;

Professional character;

Ability to work with others in a cooperative manner in the provision of health care;

Health

Professional liability coverage;

Adverse medical malpractice experience;

Query to the National Practitioner Data Bank; The Hospital shall query the Data Bank when Clinical Privileges are initially granted, at the time of renewal of Clinical Privileges, and when a new Clinical Privilege(s) is requested.

A complete application will also require the following information:

a) Names and complete addresses of at least two (2) Physicians, dentists or other practitioners, as appropriate, who have had recent extensive experience in supervising and/or observing and working with the Applicant and who can provide adequate information pertaining to the Applicant's character and current competence and professional conduct;

b) Names and complete addresses of all hospitals or other institutions at which the Applicant has worked or trained. If the number of hospitals the Applicant has worked in is great, or if a number of years has passed since the Applicant worked at a particular hospital, the Credentials Committee and the Board may take into consideration the Applicant's good faith effort to produce this information;

c) Information as to whether action has ever been taken that Adversely Affected the Applicant's Medical Staff appointment, membership or clinical privileges by or at any other hospital or health care facility or other health care delivery or managed

care organization;

d) Information as to whether the Applicant has ever withdrawn, relinquished, not renewed, been denied, or otherwise been subject to action which Adversely Affected the Applicant's application for appointment, reappointment or clinical privileges before a final decision by any governing body of a hospital or health care facility, or other professional, health care or managed care organization;

e) Information concerning the suspension or termination for any period of time of the right or privilege to participate in Medicare, Medicaid, and any other government sponsored program, or any private or public medical insurance program, and information as to whether the Applicant is currently under investigation;

f) Information as to whether the Applicant's membership in local, state or national professional associations or societies or such Applicant's license to practice any profession in any state, or such Applicant's DEA/CSR license has ever been, on a voluntary or involuntary basis, denied, revoked, suspended, reduced, withdrawn, relinquished, not renewed or otherwise Adversely Affected. The submitted application shall include a copy of all the Applicant's current licenses to practice, as well as a copy of such Applicant's DEA/CSR license, medical or dental school diploma, and certificates from all post graduate training programs completed;

g) Information as to whether the Applicant has currently in force professional liability insurance coverage, the name of the insurance company and the amount and classification of such coverage and whether the Applicant's coverage has ever been on a voluntary or involuntary basis, denied, revoked, suspended, reduced, withdrawn, relinquished, not renewed or otherwise Adversely Affected;

h) Information concerning the Applicant's involvement in professional liability actions, including, but not limited to final judgments and settlements resulting from said actions, and whether or not there is evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the Applicant;

i) Consent to the release of information from the Applicant's present and past professional liability insurance carriers;

j) Information as to whether the Applicant has ever been named as a defendant in a criminal action and details about any such instance;

k) Information on the citizenship and visa status of the Applicant;

l) Required Infectious Disease Surveillance and/or immunization requirements tracked and filed by Employee Health Services;

m) Relevant Practitioner-specific data as compared to aggregate data, when available;

n) Applicant's signature; and

o) Such other information as the Board may from time to time require.

Section 2 Undertakings:

The following undertakings shall be applicable to every Medical Staff Appointee and Applicant for Medical Staff appointment as a condition of consideration of such application and as a condition of continued Medical Staff appointment if granted:

a) Obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients within the Hospital for whom the individual has responsibility;

b) Agreement to abide by all Bylaws and policies of the Hospital, the Corporate Compliance Plan of the Hospital, and all Bylaws, Rules and Regulations of the Medical Staff (together with any amendments thereto) as shall be in force from time to time during the time the Applicant is appointed to the Medical Staff, including the Hospital's policies concerning unassigned patients, indigent and charity care, and corporate compliance;

c) Agreement to notify the President and Chief Executive Officer, in writing, no later than two (2) business days following any change in status or other action that Adversely Affects any of the following:

1) License to practice issued by a Licensing Board for Indiana or any other state or jurisdiction;

2) DEA or CSR registration;

3) Professional liability insurance coverage or qualification as a "health care provider" under Indiana's Medical Malpractice Act;

4) Board certification;

5) ACLS/CPR certification, when required;

6) Participation in Medicare, Medicaid or other federal government health care or other programs as evidenced by listing on the OIG and/or GSA "excluded individuals" databases;

7) A deterioration in physical or mental health that affects the ability to provide competent and professional health care services;

8) Any significant event resulting in an actual, pending or anticipated criminal investigation, arrest, conviction, guilty plea or a plea of "nolo contendere" to any criminal offense, whether misdemeanor or felony, in any jurisdiction, including but not limited to Indiana, not including minor traffic violations.

d) Agreement to accept committee assignments and such other reasonable duties and

responsibilities as shall be assigned to such Applicant or Appointee by the Board and the President;

e) Agreement to provide the Hospital, upon or without request, current information regarding all questions on the application form at any time, new or updated information that is pertinent to any question on the application form;

f) Statement that the Applicant has received and had an opportunity to review a copy of these Bylaws, the Hospital's Corporate Compliance Plan, Code of Conduct and other policies and procedures of the Hospital as are in force at the time of the Applicant's application (and as they may be amended from time to time) and that such Applicant has agreed to be bound by the terms thereof in all matters relating to consideration of such Applicant's application without regard to whether or not such Applicant is granted appointment to the Medical Staff or Clinical Privileges;

g) Statement of such Applicant's willingness to appear for personal interviews, submit to drug testing and physical or mental examinations in regard to such Applicant's application;

h) Statement that any misrepresentation or misstatement in, or omission from the application whether intentional or not, shall constitute cause for automatic and immediate rejection of the application resulting in denial of appointment and Clinical Privileges. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in summary dismissal from the Medical Staff;

i) Agreement of the Applicant or Appointee to submit to a physical or psychological examination by a physician, mutually acceptable to the President and the Applicant or Appointee, and who is not a member of the Applicant's or Appointee's immediate family, including spouse, parent, child or sibling (this prohibition is not applicable to in-laws or other relatives), for the purpose of determining the Applicant's or Appointee's fitness to qualify as a Medical Staff Member and to perform certain delineated Clinical Privileges, whether requested by the Executive Committee at the time of application or during any subsequent period of appointment or reappointment;

j) Obligation to use the Hospital and its facilities sufficiently to allow the Hospital, through assessment by appropriate Medical Staff committees, to evaluate in a continuing manner the current competence of the Appointee;

j) Agreement that the hearing and appeal procedures set forth herein shall be the sole and exclusive remedy with respect to any Peer Review Activity taken at the Hospital;

l) Statement that the Applicant shall:

1) Not participate in any illegal fee splitting or other illegal inducements relating to patient referral;

2) Not delegate responsibility for diagnoses or case management of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;

3) Not deceive patients as to the identity of an operating surgeon or any other individual providing treatment or services;

4) Seek consultation whenever necessary;

5) Promptly notify the President and the Chief Executive Officer, or its designee, of any change in eligibility for payments by third-party payers or for participation in Medicare, including any sanctions imposed or recommended by the Department of Health and Human Services, and/or the receipt of a PRO citation and/or quality denial letter concerning alleged quality problems in patient care;

6) Abide by all Applicable Requirements, including but not limited to all laws, regulations and generally recognized ethical principles applicable to such Applicant's profession and the performance of health care services as a member of the Hospital's Medical Staff and the general operations of the Hospital, including EMTALA;

7) Personally provide, or arrange for the provision of, continuous care for such Applicant's patients in the Hospital;

8) Authorize the release of all information necessary for an evaluation of the Applicant's or Appointee's qualifications for initial or continued appointment, reappointment, and/or Clinical Privileges;

9) Agree to hold harmless and release the Hospital, its officers, directors, or representatives, members, the Medical Staff, or anyone acting by or for the Hospital and its Medical Staff for any matter relating to the application for appointment, reappointment or Clinical Privileges, or relating to the evaluation of the Applicant's qualifications on any matter related to appointment or reappointment of Clinical Privileges;

10) Extend to and recognize immunity to the Hospital, its Medical Staff and all individuals acting by or for the Hospital and/or its Medical Staff for all matters relating to Peer Review Activity, including appointment, reappointment, and assessment for Clinical Privileges or the Applicant's or Appointee's qualifications for the same, to the fullest extent as provided for under federal and state law; and

11) Abide by the terms of the Directives promulgated by the National Conference of Catholic Bishops and to perform no activity prohibited by said Directives.

NOTE: Each Applicant for Medical Staff appointment shall specifically agree to the above undertakings as part of the Applicant's application.

Section 3 Burden of Providing Information:

The Applicant shall have the burden of producing adequate information for a proper evaluation of such Applicant's competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications. Such Applicant shall have the burden of providing evidence that such Applicant is able to perform the requested clinical privileges, with or without reasonable accommodation, and that all statements made and information given on the application are factual and true. Until the Applicant has provided all information requested by the Hospital, the application will be deemed incomplete and will not be processed.

Section 4 Authorization to Obtain Information:

a) The following statements, which shall be included on the application form and which form a part of these Bylaws, are express conditions applicable to any Applicant or Appointee to the Medical Staff and to all others having or seeking Clinical Privileges in the Hospital. By applying for appointment, reappointment or Clinical Privileges, the Applicant agrees to execute a written Authorization and Release of Liability form that expressly accepts and consents to these conditions during the processing and consideration of such Applicant's application, whether or not such Applicant is granted appointment or Clinical Privileges, and which also shall remain in effect during the time of any appointment or reappointment. The form shall incorporate the following or other comparable language approved by designated legal counsel:

1) Immunity: To the fullest extent permitted by law, the Applicant releases from any and all liability, and extends absolute immunity to the Hospital, its authorized representatives, Peer Review Committees and its authorized representatives, and any third parties as defined in subsection (d) below, with respect to any acts, communications or documents, recommendations or disclosures involving the Applicant, concerning the following:

(a) applications for appointment, reappointment, or Clinical Privileges, including temporary privileges;

(b) evaluations concerning reappointment or changes in Clinical Privileges;

(c) proceedings as a result of recommended Corrective Actions that Adversely Affect Medical Staff appointment, reappointment, or Clinical Privileges, or any other disciplinary sanction;

(d) summary suspension;

(e) hearings and appellate reviews;

(f) medical care evaluations;

(g) utilization and performance reviews;

(h) other activities relating to the quality of patient care or professional conduct;

(i) other Peer Review Activity;

(j) matters or inquiries concerning the individual's professional qualifications, credentials, clinical competence, character, ability to perform the Clinical Privileges requested, with or without reasonable accommodation, ethics or behavior; or

(k) any other matter that might directly or indirectly have an effect on the individual's competence, on patient care or on the orderly operation of this or any other Hospital or health care facility.

2) Authorization to Obtain Information: The Applicant also expressly agrees to execute a written Authorization and Release of Liability form that expressly accepts and consents to these conditions during the processing and consideration of such Applicant's application, whether or not such Applicant is granted specifically authorizes the Hospital, Medical Staff and its authorized representatives to consult with any third party who may have information bearing on the Applicant's qualifications, credentials, competence, professional conduct, character, ability to perform the Clinical Privileges requested, with or without reasonable accommodation, ethics, behavior or any other matter reasonably having a bearing on the individual's satisfaction of the criteria for initial and continued appointment to the Medical Staff. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions. The Applicant also specifically authorizes said third parties to release said information to the Hospital and its authorized representatives upon request. All such requests and receipt of information obtained under the Section shall be conducted in accordance with Applicable Requirements, including but not limited to Indiana's Peer Review Statutes.

3) Authorization to Release Information: Similarly, the Applicant specifically authorizes the Hospital, Medical Staff and its authorized representatives to release such information to other third parties, who solicit such information for the purpose of evaluating the Applicant's professional qualifications pursuant to the Applicant's application for licensure bond certification or Medical Staff appointment or Clinical Privileges. As before, all such release of information under this Section shall be conducted in accordance with Applicable Requirements, including but not limited to Indiana's Peer Review Statutes.

(a) As used in this subsection, the term "Hospital and its authorized representatives" means the Hospital corporation, the Medical Staff and any and all individuals who have any responsibility for requesting or releasing information regarding the character, qualifications, competence and professional conduct of Applicants and Appointees, including but not limited to the following: Board members and their appointed representatives; the Chief Executive Officer or its designees; Hospital and employees, contractors and consultants; Medical Staff Appointees; and designated legal counsel.

(b) As used in this subsection, the term "third parties" means any person or entity that does not otherwise qualify as the Hospital and its authorized representatives as defined under 3(a) above and from whom a request to release information regarding an individual Applicant or Appointee has been received under these Bylaws.

Section 5 Interns and Residents:

Interns and Residents undergoing training in the Hospital under the preceptorship of a Medical Staff Appointee shall not hold appointment to the Medical Staff and shall not be granted specific Clinical Privileges. Rather, they shall be permitted to exercise only those Clinical Privileges set out in training protocols developed by the Executive Committee. Residents providing locum tenens services in the Hospital (in a non-training mode) are required to hold Medical Staff appointments with delineation of Clinical Privileges.

ARTICLE 7 – PART C: PROCEDURE FOR INITIAL APPOINTMENT

Section 1 Submission of Application:

The application for Medical Staff appointment shall be submitted by the Applicant to the Chief Executive Officer or its designee. After receiving references and other information or materials deemed pertinent, the Chief Executive Officer or its designee shall determine the application to be complete and transmit the application and all supporting materials to the Credentials Committee for evaluation. It is the responsibility of the Applicant to submit a complete application, including a fully executed copy of the Authorization and Release of Liability form discussed in Article 7(C). An incomplete application will not be processed.

Section 2 Initial Credentials Committee Procedure:

a) The Credentials Committee, in addition to the Department Chairperson, shall examine the evidence of the character, qualifications, competence, professional conduct, ability to perform requested Clinical Privileges, with or without reasonable accommodation, prior behavior and ethical standing of the Applicant and shall determine, through information contained in references given by the Applicant and from other sources available to the committee, including an appraisal

from the chairperson of each department in which Clinical Privileges are sought, whether the Applicant has established and met all of the necessary qualifications for the staff category and Clinical Privileges requested by such Applicant.

b) As part of this process, if there is good reason to question the Applicant's ability to perform the Clinical Privileges requested, with or without reasonable accommodation, the Credentials Committee may require a physical and/or mental examination of the Applicant by a physician satisfactory to both the Credentials Committee and the Applicant, and shall require that the results be made available for the Credentials Committee's consideration.

c) If, after considering the finding of the chiefs of the clinical services concerned, the Credentials Committee's recommendation for appointment is favorable, the Credentials Committee shall recommend initial service assignment and initial Clinical Privileges.

d) As part of the process of making its recommendation, the Credentials Committee shall have the right to require the Applicant to meet with the committee to discuss any aspect of such Applicant's application, such Applicant's qualifications, the Clinical Privileges requested, or such Applicant's ability to perform the Clinical Privileges requested, subject to Article 4(D) of these Bylaws.

Section 3 Credentials Committee Report:

a) The Credentials Committee shall transmit to the Board through the Executive Committee the complete application and its recommendation that the Applicant be appointed to the Medical Staff, that such Applicant's application be deferred for further consideration, or that such Applicant be rejected for Medical Staff appointment. The Chairperson of the Credentials Committee or its designee shall be available to the Executive Committee and to the Board or its appropriate committee to answer any questions that may be raised with respect to the recommendation. The Board shall then consider the application at their next meeting (either a regular or a special meeting). The entire process for processing an application from receipt to Board action shall not exceed one hundred eighty (180) days.

Section 4 Subsequent Action on the Application:

a) When the recommendation of the Credentials Committee is favorable to the Applicant, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Executive Committee and then to the Board. All recommendations to appoint must also specifically recommend the Clinical Privileges to be granted and any recommendation that would Adversely Affect such Clinical Privileges. If the Board approves the Applicant's application in all respects, the action shall become effective as of the final date of the Board action. If the Board does not approve the application in all respects, resulting in a Board recommendation that Adversely Affects the Applicant's application, the Board

shall forward the recommendation to the Chief Executive Officer who shall promptly so notify the Applicant in writing, return receipt requested. The Chief Executive Officer shall then hold the application until after the Applicant has exercised or has been deemed to have waived such Applicant's right to a hearing as provided in Article 9, after which the Chief Executive Officer shall forward the recommendation of the Board, together with the application and all supporting documentation, to the Board for further action.

b) When the recommendation of the Credentials Committee is to defer the application for further consideration, it must be followed up within thirty (30) days by a subsequent recommendation to the Executive Committee and to the Board through the Chief Executive Officer for appointment to the Medical Staff with specified Clinical Privileges, or for such other recommended action that would Adversely Affect the membership or Clinical Privileges resulting from the application for staff appointment.

c) When the recommendation of the Credentials Committee involves action that would Adversely Affect either appointment to the staff or Clinical Privileges requested, it shall be forwarded to the Chief Executive Officer who shall promptly so notify the Applicant in writing, return receipt requested. The Chief Executive Officer shall then hold the application until after the Applicant has exercised or has been deemed to have waived such Applicant's right to a hearing as provided in Article 9, after which the Chief Executive Officer shall forward the recommendation of the Credentials Committee, together with the application and all supporting documentation, to the Executive Committee and to the Board.

d) The Chief Executive Officer shall promptly notify the Applicant, in writing, return receipt requested, of the Board's final action in accordance with Article 9 of these Bylaws.

ARTICLE 7 – PART D: PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES

Section 1 Temporary Clinical Privileges

a) The CEO of the Hospital or his/her designee, after conference with the President of the Medical Staff or President-Elect, shall have the authority to grant temporary privileges to a Practitioner who is not a member of the staff, or to a recognized consultant, under the following circumstances:

1. To meet an important patient care, treatment or service need (including locum tenens coverage); and

2. When a new applicant with a complete application that raises no concerns has been approved by the Credentials Committee and is awaiting review and approval of the Executive Committee and the Board.

b) Important patient care, treatment or service need: under this subcategory,

temporary privileges may be granted after verification of licensure, DEA certificate, insurance coverage, and at least one recent reference from a previous hospital, department chief or chair familiar with the current competence of the physician.

c) Temporary privileges are granted for a limited period of time not to exceed 120 days.

d) Temporary privileges are extended as a matter of grace and confer upon the recipient no membership on the medical staff, no appointment as an allied health care provider, and no rights under these Bylaws.

e) Temporary privileges may be suspended, modified or revoked at any time by the CEO of the Hospital or his/her designee or by the President of the Medical Staff without giving rise to the right to a hearing and appeal under these Bylaws.

f) Upon suspension and/or termination of temporary clinical privileges, the President of the Medical Staff or Department Chief shall have the power to assign another medical staff member to provide alternate medical care to the patients of the suspended or terminated physician or dentist, and/or to discharge such patients from the Hospital, as appropriate.

Section 2 Locum Tenens:

Temporary privileges may be granted to fulfill an important patient care, treatment, and service need. Temporary privileges for the fulfillment of important patient care, treatment, and service needs are time limited, but shall not exceed one hundred twenty (120) days for the initial period, and may be renewed for two (2) additional intervals. The Chief Executive Officer may grant an individual serving as a locum tenens temporary admitting and Clinical Privileges for a period not to exceed one hundred twenty (120) days without applying for a renewal of temporary privileges or applying for appointment to the Medical Staff. This shall be done in the same manner and upon the same conditions as set forth in Section 2 of this Part, provided that the Chief Executive Officer shall first obtain such individual's signed acknowledgment that such individual has received and had an opportunity to read copies of the Hospital bylaws, the Hospital's Corporate Compliance Plan and Medical Staff Bylaws, Rules and Regulations which are then in force and that such individual agrees to be bound by the terms thereof in all matters relating to such individual's temporary Clinical Privileges. The individual serving as a locum tenens must also complete a Request for Clinical Privileges form and must have in force and effect professional liability insurance in an amount acceptable to the Hospital.

Section 3 Special Requirements:

Special requirements of supervision and reporting may be imposed by the department chairperson or service chief concerned on any individual granted temporary Clinical Privileges. Temporary privileges shall be immediately terminated by the Chief Executive Officer or such

Chief Executive Officer's designee upon Special Notice of any failure by the individual to comply with such special conditions.

Section 4 Termination of Temporary Clinical Privileges:

a) The Chief Executive Officer or, in the Chief Executive Officer's absence, the Chief Executive Officer's designee, may at any time, after asking for a recommendation from the President or the department chairperson or service chief responsible for the individual's supervision, terminate an individual's temporary admitting privileges. Clinical Privileges shall then be terminated when the individual's in-patients are discharged from the Hospital. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual, a summary termination of temporary Clinical Privileges may be imposed by the Chief Executive Officer, service chief or President, and such termination shall be immediately effective.

b) The appropriate department chairperson or service chief or, in the absence of the appropriate department chairperson or service chief, the President, shall assign to a Medical Staff Appointee responsibility for the care of such terminated individual's patients until they are discharged from the Hospital, giving consideration whenever possible to the wishes of the patient in the selection of the substitute.

c) The granting of any temporary admitting and Clinical Privileges is a courtesy on the part of the Hospital. Neither the granting, denial, or termination of such privileges shall entitle the individual concerned to any of the procedural rights provided in these Bylaws with respect to hearings or appeals.

d) Temporary privileges shall be automatically terminated at such time as the Credentials Committee recommends unfavorably with respect to the Applicant's appointment to the staff or at the Credentials Committee's discretion shall be modified to conform to the recommendation of the Credentials Committee that the Applicant be granted different permanent privileges from the temporary privileges.

ARTICLE 7 – PART E: EMERGENCY AND DISASTER PRIVILEGES

Section 1 Emergency Clinical Privileges:

For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that harm or danger. Emergency privileges may be granted in the event of a particular patient need:

a) In an emergency involving a particular patient, a Physician who is not currently appointed to the Medical Staff may be permitted by the Hospital to exercise Clinical Privileges to act in such emergency using all necessary facilities of the Hospital, including calling for any consultation necessary or desirable.

b) Similarly, in an emergency involving a particular patient, a Physician currently

appointed to the Medical Staff may be permitted by the Hospital to act in such emergency by exercising Clinical Privileges not specifically assigned to such Physician.

c) When the emergency situation no longer exists, such Physician must request the temporary privileges necessary to continue to treat the patient. In the event such temporary privileges are denied or such Physician does not request such privileges, the patient shall be assigned by the President or its designee to an appropriate person currently appointed to the Medical Staff. The wishes of the patient shall be considered in the selection of the substitute Physician.

Section 2 Disaster Privileges:

For the purpose of this Section, a "disaster" is defined as any occurrence of officially declared emergency, whether internal and/or external, that inflicts destruction, harm, or distress and that creates healthcare demands that exceed the capabilities of the Hospital and/or the Medical Staff, whether local, state, or national. In all such disasters, the requirements governing emergencies hereunder shall apply:

a) Disaster privileges may be granted to volunteers eligible to be licensed independent practitioners when the disaster (emergency management) plan has been activated and the Hospital is unable to handle the immediate patient needs.

b) Even in a disaster, the integrity of two (2) parts of the usual credentialing and privileging process must be maintained: verification of licensure and oversight of the care, treatment, and services provided. The option to grant disaster privileges to volunteer practitioners is made on a case-by-case basis in accordance with the needs of the Hospital and its patients, and on the qualifications of its volunteer practitioners.

c) While disaster privileges are granted on a case-by-case basis by the President and Chief Executive Officer or their respective designee(s), volunteers considered eligible to act as licensed independent practitioners in the Hospital must at a minimum present a valid government-issued photo identification issued by a state or federal agency (e.g., a driver's license or passport) and at least one (1) of the following: a current picture hospital ID card that clearly identifies professional designation, a current license to practice, primary source verification of the license, and a valid picture ID issued by a state, federal, or regulatory agency; identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal organization(s) or group(s); identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances, such authority having been granted by a state, federal, or municipal entity; or presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity and ability to act as a licensed independent practitioner during a disaster.

d) The President or its designee will manage the activities of individuals who receive emergency privileges, either through direct observation, mentoring or clinical record review. The Hospital Emergency Incident Command System will prepare identification badges for all emergency staff, including Physicians.

e) The Medical Staff addresses the verification process as a high priority. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within seventy-two (72) hours from the time the volunteer practitioner presents to the organization. The Hospital makes a decision (based on information obtained regarding the professional practice of the volunteer) within seventy-two (72) hours related to the continuation of the disaster privileges initially granted.

f) Disaster privileges shall terminate immediately when the emergency is declared over by an authorized public official. Disaster privileges may also be immediately terminated, with or without cause, by the Chief Executive Officer and the President, or their respective designees. Notwithstanding any other provision of these Bylaws, any such termination of disaster privileges shall not give rise to any fair hearing or appeal rights hereunder.

ARTICLE 8
ACTIONS AFFECTING MEDICAL STAFF APPOINTEES

ARTICLE 8 – PART A: PROCEDURE FOR REAPPOINTMENT

Section 1 Application:

Each current Appointee who wishes to be reappointed to the Medical Staff shall be responsible for completing the reappointment application form approved by the Board. The reappointment application shall be sent to each Medical Staff Appointee one hundred eighty (180) days prior to the expiration of the Appointee's then current appointment. The completed reappointment application will be submitted to the Chief Executive Officer or its designee within sixty (60) days of receipt by the current Appointee. If not received within thirty (30) days, a certified letter will be sent to the current Appointee requesting submission of the completed reappointment application within thirty (30) more days. Failure to submit an application by that time will result in automatic expiration of the Appointee's appointment and Clinical Privileges at the completion of the then current appointment period, and reappointment to the Medical Staff will then require full reapplication as in Article 7, for initial appointment. Reappointment, if granted, shall be for a period of not more than three (3) years.

Section 2 Factors to be Considered:

Each recommendation concerning reappointment of a person currently appointed to the Medical Staff or a change in staff category, where applicable, shall be based upon such Appointee's:

a) Clinical competence and professional conduct in the treatment of patients;

b) Compliance with all Applicable Requirements pertaining to such Appointee's profession, reimbursement for such Appointee's services or the services of the Hospital, and the general operation of the Hospital, including, but not limited to, the EMTALA;

c) Behavior in the Hospital, such Appointee's cooperation with medical and Hospital personnel as it relates to patient care and the orderly operation of the Hospital, and such Appointee's general attitude toward patients, the Hospital and its personnel in accordance with Applicable Requirements, including but not limited to, the Hospital's Code of Conduct;

d) Use of the Hospital's facilities for such Appointee's patients;

e) Ability to perform the requested Clinical Privileges, with or without reasonable accommodation, including any information that the Appointee has not practiced outside the scope of his privileges;

g) Capacity to satisfactorily treat patients as indicated by the results of the Hospital's

quality assessment activities or other reasonable indicators of continuing qualifications, including OPPE and FPPE evaluations described in Article 8 (C);

h) Satisfactory completion of such continuing education requirements as may be imposed by law, the Hospital or applicable accreditation agencies, and provide copies of all documentation regarding continuing education activities to the Medical Staff Coordinator for placement in the credentials file, as applicable;

i) Information as to whether the Appointee's Medical Staff appointment or Clinical Privileges has been Adversely Affected at any other hospital or health care facility, unless such action was for less than thirty (30) days for medical records delinquency;

j) Information as to whether the Appointee has withdrawn, relinquished or not renewed such Appointee's application for appointment, reappointment and Clinical Privileges before final decision by a hospital's or health care facility's governing board;

k) Information as to whether the Appointee's membership in local, state or national professional societies or such Appointee's license to practice any profession in any state, or such Appointee's DEA license has been suspended, modified or terminated, or voluntarily relinquished;

l) Information as to whether the Appointee has currently in force professional liability insurance coverage, the name of the insurance company and the amount and classification of such coverage;

m) Information concerning Appointee's malpractice litigation experience, including any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the Appointee;

n) Information as to whether the Appointee has been named as a defendant in a criminal action and details about any such instance;

o) Information on the citizenship and visa status of the Appointee;

p) Documentation as to the Appointee's health status;

q) Relevant practitioner specific data are compared to aggregate data, when available;

r) Board certification status, as outlined in Article 7(A)(2);

s) performance measurement data, including morbidity and mortality data, when available; and

t) Results of verifications to ensure that the Appointee has not been excluded from participation in Medicare or other federally funded programs.

Section 3 Department Procedure:

a) No later than two (2) months prior to the end of the current appointment period, the Chief Executive Officer or its designee shall send to the Credentials Committee the list of those Appointees desiring reappointment. The Credentials Committee shall then in turn transmit to the chairperson of each department a current list of all Appointees who have Clinical Privileges in that service, together with the Clinical Privileges each then holds, accompanied by copies of their applications.

b) No later than fifteen (15) days after the chairperson of each department receives the application, the chairperson of each department shall transmit to the Credentials Committee the list of individuals recommended for reappointment in the same Medical Staff category with the same Clinical Privileges they then hold. In addition, the chairperson shall submit individual findings, and the reasons therefore, for any changes recommended in staff category, in Clinical Privileges, or for non-reappointment both for those who applied for changes and those who did not.

c) Findings pertaining to the increase or decrease of Clinical Privileges shall be based upon:

1) Relevant recent training;

2) Observation of patient care provided;

3) Review of the records of patients treated in the Hospital or other hospitals;

4) Results of the Hospital's quality assessment activities; and

5) Other reasonable indicators of the individual's continuing qualifications for the privileges in question.

Section 4 Credentials Committee Procedure:

a) After receiving recommendations from the chairperson of each department, the Credentials Committee shall review all pertinent information available, including all information provided from other committees of the Medical Staff and from Hospital management, for the purpose of determining its recommendations for staff reappointment, for change in staff category, and for the granting of Clinical Privileges for the ensuing appointment period.

b) The Credentials Committee may recommend less than a three (3) year reappointment in cases where it is determined that the Appointee has not met meeting attendance requirements as outlined in these Bylaws.

c) The Credentials Committee may require, in conjunction with the Practitioner Assistance Committee, that an individual currently seeking reappointment procure a physical and/or mental examination by a physician(s) satisfactory to the

Credentials Committee either as part of the reapplication process or during the appointment period to aid it in determining whether Clinical Privileges should be granted or continued and make results available for the Credentials Committee's consideration. Failure of the individual seeking reappointment to procure such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall render the Applicant's application for reappointment incomplete until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon. Any other failure to procure such an examination during the appointment period shall be reported to the President under Article 8(C)(3).

d) The Credentials Committee shall prepare a list of Appointees currently holding appointment who are recommended for reappointment without change in staff category and Clinical Privileges. Recommendations for non-reappointment, for changes in staff category or Clinical Privileges, or for any other reason that may Adversely Affect the membership or Clinical Privileges, with supporting data and reasons attached, shall be handled individually.

e) The Credentials Committee shall transmit its report and recommendations to the Executive Committee and then to the Board through the Chief Executive Officer in time for the Board to consider reappointments at its final scheduled meeting in each reappointment cycle.

f) When the recommendation of the Credentials Committee involves action that would Adversely Affect the Appointee's Medical Staff status or Clinical Privileges requested, it shall be forwarded to the Chief Executive Officer who shall promptly provide Special Notice to the Appointee. The Chief Executive Officer shall then hold the application until after the Appointee has exercised or has been deemed to have waived such Appointee's right to a hearing as provided in Article 9, after which the Chief Executive Officer shall forward the recommendation of the Credentials Committee, together with the application and all supporting documentation, to the Executive Committee and to the Board. If for any reason the application for reappointment has not been finally acted on by the Board prior to the end of the appointment year, then the current appointment and Clinical Privileges shall continue until final action of the application is taken by the Board.

Section 6 Undertakings:

The following undertakings shall be applicable to every Applicant for Medical Staff reappointment as a condition of consideration of such application and as a condition of continued Medical Staff appointment if granted:

a) Obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients within the Hospital for whom the individual has responsibility;

b) Agreement to abide by all Bylaws and policies of the Hospital, the Corporate Compliance Plan of the Hospital and all Rules and Regulations of the Medical Staff (together with any amendments thereto) as shall be in force from time to time during the time the Applicant is appointed to the Medical Staff, including the Hospital's policies concerning unassigned patients, indigent and charity care, and corporate compliance;

c) Agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned to such Applicant by the Board and the President;

d) Agreement to provide the Hospital, upon request or without request, current information regarding all questions on the application form at any time, new or updated information that is pertinent to any question on the application form;

e) Agreement to notify the President and Chief Executive Officer, in writing, no later than two (2) business days following any change in status or other action that "Adversely Affects" any of the following:

1) License to practice issued by a Licensing Board for Indiana or any other state or jurisdiction;

2) DEA or CSR registration;

3) Professional liability insurance coverage or qualification as a "health care provider" under Indiana's Medical Malpractice Act;

4) Board certification;

5) ACLS/CPR certification, when required;

6) Participation in Medicare, Medicaid or other federal government health care or other programs as evidenced by listing on the OIG and/or GSA "excluded individuals" databases;

7) A deterioration in physical and/or mental health that affects the ability to provide competent and professional health care services;

8) Any significant event resulting in an actual, pending or anticipated criminal investigation, arrest, conviction, guilty plea or a plea of "nolo contendere" to any criminal offense, whether misdemeanor or felony, in any jurisdiction, including but not limited to Indiana, not including minor traffic violations.

f) Statement that the Applicant has received and had an opportunity to review a copy of the Medical Staff Bylaws, Rules and Regulations, the Corporate Compliance Plan, Code of Conduct and other policies and procedures of the Hospital as are in force at the time of the Applicant's application (and as they may be amended from time to time) and that such Applicant has agreed to be bound by the terms thereof

in all matters relating to consideration of such Applicant's application without regard to whether or not such Applicant is granted appointment to the Medical Staff or Clinical Privileges;

g) Statement of such Applicant's willingness to appear for personal interviews, drug tests and physical and medical examinations in regard to such Applicant's application;

h) Statement that any misrepresentation or misstatement in, or omission from the application whether intentional or not, may constitute cause for automatic and immediate rejection of the application resulting in denial of appointment and Clinical Privileges. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in summary dismissal from the Medical Staff;

i) Statement that the Applicant shall:

1) Not participate in any splitting or other inducements relating to patient referral;

2) Not delegate responsibility for diagnoses or case management of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;

3) Not deceive patients as to the identity of an operating surgeon or any other individual providing treatment or services;

4) Seek consultation whenever necessary;

5) Abide by all Applicable Requirements, including but not limited to all laws, regulations and generally recognized ethical principles applicable to such Applicant's profession, and the performance of health care services as a Member of the Medical Staff and the general operations of the Hospital, including the EMTALA;

6) Personally provide, or arrange for the provision of, continuous care for such Applicant's patients in the Hospital; and

7) Abide by the terms of the Directives promulgated by the National Conference of Catholic Bishops and to perform no activity prohibited by said Directives.

NOTE: Each Applicant for Medical Staff reappointment shall specifically agree to the above undertakings as part of the Applicant's application.

Section 7 Senior Medical Staff:

NOTE: Any competence or professional conduct issues that may arise between re-appointment applications shall be handled in accordance with Article 8(D) (Collegial Intervention, Procedure for Initiating an Investigation and Corrective Action Involving Appointees).

a) Medical Staff Members shall maintain mental and physical competency attributes which enable her/him to practice in a competent, professional and ethical manner in accordance with Applicable Requirements, including but not limited to these Bylaws and other applicable standard of care levels for her/his field.

b) The Medical Staff must balance patient protection with the responsibilities required to give each Member her/his due process when competence or professional conduct questions arise.

c) Concerns regarding competence and professional conduct may arise for any Medical Staff Member, regardless of age. Any Medical Staff Member whose mental or physical competency is under scrutiny will undergo the formalities developed for reviewing the competence and professional conduct of the Medical Staff Member in accordance with Article 8 (D) of these Bylaws. Additionally, as part of the reappointment process, the following requirements apply:

    1) The Senior Medical Staff Member shall be defined as any Practitioner who is aged sixty-seven (67) or older at the time of reappointment to the Medical Staff.

    2) Any and all Senior Medical Staff Members will be required to apply for and complete the Medical Staff reappointment process set forth herein annually, rather than triennially.

    3) Medical Staff Members attaining the age of sixty-seven (67) will no longer be required to participate in the ER call schedule.

    4) The Credentials Committee may recommend reappointment of the Senior Medical Staff Member without limitation for a one (1) year period, or alternatively, the Credentials Committee may recommend one (1) or more of the following:

        (a) Corrective Action that Adversely Affects the Senior Medical Staff Member's status (e.g., denial, limitation, suspension, proctoring or supervision which requires concurrent review and pre-approval of performance, acceptance of resignation during credentialing process) as defined by the Bylaws, for which hearing rights would be made available prior to any final action that would result in a Data Bank report; or

(b) Corrective Action that does not Adversely Affect the Senior Medical Staff Member's status (e.g., probation, retrospective review of performance), as defined by the Bylaws, for which no hearing rights would be available nor any Data Bank report would be required.

d) This policy will be implemented in compliance with all Applicable Requirements including but not limited to the Americans with Disabilities Act.

ARTICLE 8 – PART B: PROCEDURES FOR REQUESTING INCREASE IN PRIVILEGES

Section 1 Application for Increased Clinical Privileges:

Whenever, during the term of an Appointee's appointment to the Medical Staff, an Appointee desires to increase such Appointee's Clinical Privileges, such Appointee shall apply in writing to the Chief Executive Officer or its designee. The application shall state in detail the specific additional Clinical Privileges desired and the Appointee's relevant recent training and experience which justify increased privileges. This application will be transmitted by the Chief Executive Officer to the Credentials Committee and by the Credentials Committee to the appropriate department. Thereafter, it will be processed in the same manner as an application for initial Clinical Privileges if the request is made during the term of appointment, or as a part of the reappointment application if the request is made at that time.

Section 2 Factors to be Considered:

Recommendations for an increase in Clinical Privileges made to the Board shall be based upon:

a) Relevant recent training;

b) Observation of patient care provided;

c) Review of the records of patients treated in the Hospital or other hospitals;

d) Findings or results of the Hospital's quality assessment activities;

e) Applicant's ability to meet the qualifications and criteria for the additional Clinical Privileges requested; and

f) Other reasonable indicators of the Applicant's continuing qualifications for the Clinical Privileges in question.

The recommendation for such increased Clinical Privileges may carry with it such requirements for supervision or consultation for such period of time as are thought necessary.

ARITICLE 8 – PART C: FOCUSED PROFESSIONAL PRACTICE EVALUATION AND ONGOING PROFESSIONAL PERFORMANCE EVALUATION

Section 1 Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Performance Evaluation (OPPE):

As part of the quality assessment and performance improvement plan for the Hospital and Medical Staff, all Practitioners will be evaluated through the FPPE and OPPE processes as outlined in the corresponding policies and procedures in place. FPPE process is used for all Practitioners at the time of initial appointment to the Medical Staff when granted Clinical Privileges as well as when any new Clinical Privileges have been granted. OPPE process is used for all Practitioners on an ongoing and routine basis during their appointment term and between reappointments to the Medical Staff.

Section 2 Focused Professional Practice Evaluation

The Medical Staff has defined the circumstances requiring monitoring and evaluation of a Practitioner's professional performance in the peer review protocol set forth in the FPPE policy and in specific department peer review policies and procedures. Such monitoring may use prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, tracking performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of the patient.

Section 3 Ongoing Professional Practice Evaluation

The Medical Staff will also engage in ongoing evaluation through the OPPE process to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to allow Practitioners to maintain existing privileges, revise existing privileges, or revoke an existing privilege prior to or at the time of reappointment. OPPE shall be undertaken as part of the Medical Staff's evaluation, measurement, and improvement of each Practitioner's current clinical competency. In addition, each Practitioner may be subject to FPPE when issues affecting the provision of safe, high-quality patient care are identified during the OPPE process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

ARTICLE 8 – PART D: COLLEGIAL INTERVENTION; PROCEDURE FOR INITIATING AN INVESTIGATION AND CORRECTIVE ACTION INVOLVING APPOINTEES

Section 1 Collegial Intervention:

Nothing in these Bylaws shall prevent a Medical Staff officer or a chairperson of a department or committee from conducting a Collegial Intervention with a Practitioner for the purpose of reviewing, preventing or mitigating facts or circumstances that may call into question the competence or professional conduct of a Practitioner and that may otherwise require the initiation of Corrective Action under this Article if not resolved at this level.

Section 2 Non-Adverse Action:

For purposes of these Bylaws, any initiation of Collegial Intervention or other action recognized by the National Practitioner Data Bank ("NPDB" or "Data Bank") Guidebook (Chapter E: Reports) as a Non-Adverse Action that is not reportable to the NPDB shall not qualify as Corrective Action unless other steps are initiated under Section 3 of this Article.

Section 3 Initiation of Corrective Action:

a) If the President, the chairperson of a particular Medical Staff department or committee, Chief Medical Officer, or the Chief Executive Officer of the Hospital has reason to believe that the competence, or professional conduct of any Appointee has been, or is reasonably probable of being, detrimental to patient care, disruptive to Hospital operations, or otherwise deviates from the Medical Staff requirements set forth in these Bylaws, then such person(s) may submit a written request for investigation ("Request for Corrective Action") to the President (or other Medical Staff officer or immediate past president, in the President's absence), or alternatively, if the matter concerns the President, to the Chief Executive Officer.

b) A copy of the Request for Corrective Action shall also be given to the subject Appointee by Special Notice.

c) The receipt of the Request for Corrective Action by the President (or other Medical Staff officer in the President's absence) marks the onset of a formal investigation under these Bylaws.

d) The Request for Corrective Action must identify the specific acts, activities or conduct that call into question the competence or professional conduct of the subject Appointee and which constitutes the grounds for the Request for Corrective Action, including but not limited to the following:

    1) Clinical competence of the subject Appointee;

    2) Care or treatment of a patient or patients or management of a case by the subject Appointee;

    3) Known or suspected violation by the subject Appointee of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Hospital, or the Board or the Medical Staff, including Applicable Requirements, including but not limited to the Hospital's quality assessment, risk management, and utilization review, Medical Staff Bylaws, the Corporate Compliance Plan, Code of Conduct or other policies, procedures and programs of the Hospital;

    4) Behavior or the professional conduct of a subject Appointee that is considered to be illegal, unethical, unprofessional, or lower than the standards of the Hospital or, disruptive of the orderly operation of the Hospital or the Medical Staff, including the ability of the subject Appointee to work harmoniously with others; or

5) Impaired Practitioner's failure to progress or otherwise comply with all treatment requirements or any and all state or local professional association or Licensing Board requirements which were previously monitored by the Practitioner Assistance Committee under Article 6 – Part L of these Bylaws.

e) Within five (5) days, the President (or its designee or other Medical Staff officer in the President's absence) and the Credentials Committee shall review the Request for Corrective Action and determine if there is reliable information which indicates that the subject Appointee may have exhibited acts, demeanor or conduct reasonably likely to be:

1) Detrimental to personal safety or the delivery of quality patient care services within the Hospital;

2) Contrary to the Bylaws, Rules and Regulations and any violation of the Applicable Requirements, including but not limited to these Bylaws, the Corporate Compliance Plan, Code of Conduct or other policies, procedures, resolutions, or other programs of the Hospital;

3) Disruptive to the Hospital, the Medical Staff or the Board, or general Hospital operations;

4) In violation of applicable laws or regulations; or

5) Below applicable professional, ethical and clinical standards.

Section 4 Investigative Procedure:

a) If, in the opinion of the President (or other Medical Staff officer or the immediate past president in the President's absence) and the Credentials Committee, the Request for Corrective Action contains information sufficient to warrant an investigation, then the President (or other Medical Staff officer or immediate past president acting in the President's absence) shall appoint an Investigating Committee.

1) This Investigating Committee shall consist of three (3) persons, at least two (2) of whom shall hold appointments to the Medical Staff. This Investigating Committee shall not include partners, associates, or relatives of the subject Appointee or any Members of the Credentials Committee, nor shall this Investigating Committee include any person with a Conflict of Interest or who is otherwise in direct economic competition with the subject Appointee, or any person who shall serve as a decision-maker in any subsequent and related hearing or appeal procedure.

2) The Investigating Committee shall have available to them the full resources of the Medical Staff and the Hospital to aid in their work, as well as the authority to use outside consultants as required.

3) The subject Appointee shall have an opportunity to meet with the Investigating Committee before it makes its report. At this meeting, the subject Appointee shall be informed of the general nature of the evidence supporting the Request for Corrective Action and shall be invited to discuss, explain or refute it. This meeting shall not constitute a hearing and none of the procedural rules provided in these Bylaws with respect to hearings shall apply to this meeting, nor shall any party have legal counsel present during this meeting. No record or minutes of the meeting shall be made by any person. At the conclusion of the investigation and within a reasonable time after the Investigating Committee's receipt of the Request for Corrective Action, the Investigating Committee shall submit a confidential investigative report to the President and Credentials Committee.

4) The President shall submit the Investigating Committee's report to the Executive Committee with any recommendation by the President or the Credentials Committee to accept, modify or reject any part of the Investigating Committee's report.

Section 5 Summary Suspension:

a) If at any time, the President (or other Medical Staff officer or immediate past president acting in the President's absence), the Credentials Committee Chairperson (or other member of the Credentials Committee acting in the Chairperson's absence), and the Chief Executive Officer have reason to believe that the acts or omissions of any Appointee may threaten the health or welfare of any patient or other person on Hospital premises, or may severely disrupt or threaten the orderly operations of the Hospital, may act as a Peer Review Committee for the purpose of summarily suspending all or any part of the Clinical Privileges of an Appointee. This summary suspension shall become effective immediately.

b) The President shall promptly give Special Notice, and if possible, verbal notice of the summary suspension to the subject Appointee. The President shall also summarily inform the Board and the Hospital's legal counsel.

c) The President shall coordinate and reassign, as necessary, the ongoing treatment needs of Hospital inpatients under the care of the subject Appointee at the time of the summary suspension.

d) Any summary suspension that is the result of a Corrective Action under these Bylaws, and which is imposed and remains in effect for more than thirty (30) days shall be reported to the Data Bank. If the Board should later modify, revise, or reverse the summary suspension, the revision is also reported to the Data Bank and the Licensing Board.

e) Credentials Committee.

1) As soon as possible, but no later than fourteen (14) days following the effective date of the summary suspension, the Chairperson of the Credentials Committee shall call a special meeting of the Credentials Committee to determine whether the terms of the subject Appointee's summary suspension should be modified, continued, or terminated. The Chairperson shall invite the subject Appointee to appear at the meeting, if available.

2) The Credentials Committee, by a majority vote, shall have the authority to modify, continue or terminate the subject Appointee's summary suspension, and any such action shall become effective immediately.

f) Special Notice. The Chief Executive Officer shall promptly give Special Notice to the subject Appointee of the Credentials Committee's action to modify, continue or terminate the summary suspension and any related hearing rights under Article 9 of these Bylaws. The Chief Executive Officer shall also inform the Board and the Hospital's legal counsel.

Section 6 Procedure Thereafter:

a) At the completion of investigation of the Request for Corrective Action of a particular Medical Staff department or committee, under Article 8(D)(4), the Credentials Committee shall submit its final recommendation, and any recommendations of the Executive Committee and/or to the Board. The recommendation shall state and determine whether the Request for Corrective Action is meritorious, and if so, recommend any Corrective Action that is to be initiated in response to the Request for Corrective Action. In any case, the Credentials Committee's recommended action may include, without limitation:

1) Corrective Action;

2) Other Non-Adverse Action or other remedial action as further described under Article 8(D)(2) not qualifying as Corrective Action, including but not limited to:

(a) Issuance of a letter of admonition, censure, reprimand or warning, in which case the subject Appointee may make a written response that is placed in the subject Appointee's Credentials file stored in the Medical Staff Office;

(b) Initiation of monitoring, proctoring, probation or other review procedures that do not otherwise restrict in any way the subject Appointee's ability to exercise Clinical Privileges; or

(c) Action not qualifying as Corrective Action or that is not based upon the competence or professional conduct of the subject Appointee, including but not limited to the failure to complete medical records or billing statements, or failure to attend Medical Staff meetings;

3) Deferral of action, in which case adverse information is retained in the subject Appointee's file for a reasonable period of time; or

4) No action, based upon the absence of any credible evidence to support the Request for Corrective Action, in which case all adverse information is removed from the subject Appointee's file.

b) Any recommendation by the Credentials Committee for Corrective Action which is based on the subject Appointee's competence or professional conduct, and which would Adversely Affect the subject Appointee's Medical Staff membership or Clinical Privileges for a term of thirty (30) days or more after the Credentials Committee acts, shall entitle the subject Appointee to the procedural rights provided in Article 9. Such a recommendation shall be forwarded to the Chief Executive Officer who shall promptly provide Special Notice to the subject Appointee. The Chief Executive Officer shall then hold the recommendation until after the subject Appointee has exercised or has been deemed to have waived his/her right to a hearing as provided in Article 9. At the time the subject Appointee has been deemed to have waived his/her right to a hearing, the Chief Executive Officer shall forward the recommendation of the Credentials Committee, together with all supporting documentation, to the Board. The President (or its designee) and the Chairperson of the Credentials Committee (or its designee) shall be available to the Board, or its appropriate Board Executive Committee, to answer any questions that may be raised with respect to the recommendation.

c) If the action of the Credentials Committee does not qualify as Corrective Action that extends for a term of thirty (30) days or more, the action shall take effect immediately without action of the Board and without the right of appeal to the Board. A report of the action taken and reasons therefore shall be made to the Board through the Chief Executive Officer and the action shall stand unless modified by the Board. In the event the Board determines to consider modification of the action of the Credentials Committee and such action would in turn Adversely Affect the membership or Clinical Privileges of the Medical Staff Appointee for thirty (30) days or more, it shall so notify the subject Appointee, through the Chief Executive Officer, and shall take no final action thereon until the subject Appointee has exercised or has been deemed to have waived the procedural rights provided in Article 9.

d) The Board shall report any and all final Corrective Action to the Data Bank by way of the Licensing Board in accordance with Applicable Requirements. The Board shall also report any acceptance of the surrender, withdrawal, relinquishment or other non-renewal of membership or Clinical Privileges of the subject Appointee in return for not conducting an investigation of the subject Appointee under Article 8 of the Bylaws. Any Summary Suspension that Adversely Affects the Clinical Privileges of an Appointee for a period longer than thirty (30) days, and which is based on the competence or professional conduct of the subject Appointee, shall be reported to the Data Bank in accordance with Applicable Requirements.

e) The Chairperson of the Credentials Committee shall promptly notify the Executive Committee in writing of all Requests for Corrective Action regarding a subject Appointee received by the Credentials Committee and keep the President and Chief Executive Officer and Executive Committee fully informed of all action taken in connection therewith.

Section 7 Report to Executive Committee:

Prior to the time the Credentials Committee makes its recommendation to the Board, it shall transmit a copy thereof to the Executive Committee of the Medical Staff for information and possible comment. The Executive Committee shall have the right to comment directly to the Board for its consideration on any recommendation of the Credentials Committee. In those instances in which the Appointee affected by the recommendation is entitled to the procedural rights provided in Article 9, but has not as yet exercised them, the Executive Committee shall not comment on the recommendations of the Credentials Committee until a hearing has been held and a final recommendation submitted to the Board or until the subject Appointee has been deemed to have waived his/her procedural rights.

ARTICLE 8 – PART E: SUMMARY SUSPENSION OF CLINICAL PRIVILEGES

Section 1 Grounds for Summary Suspension:

Any Summary Suspension shall entitle the subject Appointee to the procedural rights provided in Article 9. In all cases, the Chief Executive Officer shall promptly provide Special Notice to the subject Appointee personally, if possible.

ARTICLE 8 – PART F: AUTOMATIC SUSPENSION

Section 1 Failure to Complete Medical Records:

The Clinical Privileges of any Appointee shall be automatically suspended for failure to complete medical records after notification of the President of such delinquency. Such suspension shall continue until all the records of the Appointee's patients are no longer delinquent. Failure to complete the medical records that caused suspension within thirty (30) days of notification shall constitute a voluntary resignation from the Medical Staff for which no hearing rights under Article 9 apply.

Section 2 Action by Licensing Board:

Any action by the appropriate Licensing Board, specialty board, or other federal or state agency that Adversely Affects a Practitioner's professional license, board certification, or CSR, shall result in an automatic suspension of all Hospital Clinical Privileges as of that date, until the matter is resolved and the particular credential is restored. As soon as possible after such action, the Credentials Committee shall initiate Corrective Action as is required in the manner specified in this Article 8, as appropriate.

Section 3 Failure to Comply with Government and Other Third-Party Payor Requirements:

Any action by a government agency or other third party payor that Adversely Affects a Practitioner's participation in a government or other third party payor's health benefit program, including but not limited to exclusion or other sanction, due to the Practitioner's failure to comply with Applicable Requirements shall result in an automatic suspension of all Hospital Clinical Privileges as of that date, until the matter is resolved and the Practitioner's participation or other status is fully restored. As soon as possible after such action, the Credentials Committee shall initiate Corrective Action as is required in the manner specified in this Article 8, as appropriate.

Section 4 Failure to be Adequately Insured:

If, at any time a Practitioner's professional liability insurance coverage lapses, falls below the required minimum, is terminated, not renewed, or otherwise ceases to be in effect, the Practitioner's Clinical Privileges shall be automatically suspended as of that date until the matter is resolved and adequate professional liability insurance coverage is restored. As soon as possible after such action, the Credentials Committee shall take such further action as is required in the manner specified in Part D of this Article 8, as appropriate.

Section 5 Automatic Suspension:

a) Special Notice. The President shall promptly give Special Notice, and if possible, verbal notice of the automatic suspension to the Practitioner. The President shall also summarily inform the Credentials Committee, the Board and the Executive Director.

b) Coordination of Care. The President shall coordinate and reassign, as necessary, the ongoing treatment needs of persons in the Hospital under the care of the Practitioner at the time of the Automatic Suspension.

c) No Hearing Rights; Data Bank Report. In the case of any Automatic Suspension initiated pursuant to this Section, the Practitioner shall have no hearing rights under these Bylaws, nor is a Data Bank Report necessary, unless otherwise required by Applicable Requirements.

Section 6 Leave of Absence:

a) A Practitioner may obtain a voluntary leave of absence from the Medical Staff by submitting written notice to the President of the period of time required for the leave, which may not exceed twelve (12) months, with the option for renewal by the Credentials Committee for an additional twelve (12) months.

b) A Practitioner may seek reinstatement at any time during, or at least sixty (60) days prior to the expiration of the leave of absence by submitting a written request to the President. Any written request for reinstatement shall be accompanied by a detailed, written summary of relevant professional activities performed during the leave of absence period. The request for reinstatement shall be processed by the Credentials Committee and the Board as if the Practitioner was submitting an Application for the first time.

c) If the Practitioner's leave of absence period includes no relevant professional activities for at least six (6) months, the Credentials Committee may require proof of competency through one (1) or more of the following:

1) Additional continuing education;

2) The results of a self-query to the Data Bank;

3) Appropriate monitoring by a designated Active Staff Appointee, approved by the Board, for a period of time to ensure continuing confidence.

d) If a Practitioner requests a leave of absence for purposes of:

1) Armed services obligations, if otherwise qualified to do so, reinstatement shall become automatic upon written notice that armed services obligation has been completed;

2) Obtaining further professional training, reinstatement shall become automatic upon written notice that the training has been completed. Any additional written request related to the reinstatement, whether for modified, enlarged, or additional Clinical Privileges or other change in status, shall be processed as if the Practitioner was submitting an application for the first time.

3) Medical treatment or rehabilitation, a reinstatement shall become effective only after the following conditions have been met:

(a) A written request for reinstatement is submitted to the President;

(b) The President, Chief Executive Officer and the Practitioner enter into a "return to work" agreement which shall provide for any necessary requirements, including but not limited to monitoring, reporting, and announced/unannounced testing that may be required, upon the recommendation of the Practitioner's treating physician(s), Licensing Board, professional organization's assistance program, or any combination thereof; and;

(c) The request for reinstatement shall be processed by the Credentials Committee and the Board according to these Bylaws as if the Practitioner was submitting an application for the first time.

e) Failure to request reinstatement at least sixty (60) days prior to the completion of the leave of absence, or to provide the detailed, written summary of relevant professional activities performed during the leave of absence period noted above, without "good cause," shall constitute a voluntary resignation from the Medical Staff, and shall result in automatic termination of Medical Staff membership effective at the expiration of the Practitioner's leave of absence without any right to a hearing as provided in Article 9.

f) Any subsequent request or Application for reappointment that is received from a Practitioner following such termination shall be processed by the Credentials Committee and the Board as if the Practitioner was submitting an application for the first time.

ARTICLE 9
HEARING AND APPEALS PROCEDURE

The Board of Directors, the departments and committees of the Hospital and the Medical Staff, in order to evaluate the qualifications of health care providers and the professional care rendered to patients by said health care providers, hereby constitute themselves as professional review committees engaged in Professional Review Activity as defined by law. The professional review committees herein enumerated claim all rights, privileges and immunities afforded by all state and federal law. The purpose of the Hearing and Appeals Procedure ("Plan") set forth in this Article 9 is to provide a mechanism through which a fair hearing and appeal is available to all Practitioners against whom Adverse Action is taken. This Plan is intended to comply with the Indiana Peer Review Act, the Indiana Hospital Licensure Act, and the Health Care Quality Improvement Act.

Any action pursuant to this Plan, shall be taken (i) in the reasonable belief that the action is in the furtherance of quality health care; (ii) after a reasonable effort to obtain the facts; (iii) after adequate notice and hearing procedures are afforded to any Practitioner involved; and (iv) in the reasonable belief that the action taken is warranted by the facts.

ARTICLE 9 – PART A: INITIATION OF HEARING

Unless waived, a Medical Staff Applicant or Appointee shall be entitled to all hearing and appeal rights and procedures set forth in these Bylaws if any of the following actions are recommended:

a) Denial of a complete Application for initial appointment to the Medical Staff, and Clinical Privileges, except for the following reasons:

   1) The subject Applicant failed to submit a complete Pre-application Form, and a request for specific Clinical Privileges;

   2) The Pre-application does not meet the minimum qualifications set forth in the Bylaws;

   3) The subject Applicant withdraws a complete Application and request for specific Clinical Privileges due to the failure to document or demonstrate compliance with all minimum qualifications;

   4) The subject Applicant's application seeks Medical Staff appointment or Clinical Privileges in a department in which the number or type of Practitioners has been limited in accordance with the Board; or

   5) When the subject Applicant's application is submitted less than one (1) year after an earlier original Corrective Action that resulted in the denial or termination of membership status, during which time period the subject Applicant was not eligible to re-apply to the Medical Staff, pursuant to these Bylaws.

b) Denial of a completed Application for reappointment to the Medical Staff, except for the following reasons:

1) The subject Appointee failed to submit a complete Application for reappointment, and a request for specific Clinical Privileges, without good cause, as required prior to the expiration of any current appointment period;

2) The subject Appointee withdraws a complete Application for reappointment to the Medical Staff due to the failure to document or demonstrate compliance with all minimum qualifications for Medical Staff membership; or

3) The subject Appointee's Application seeks reappointment status, or specific Clinical Privileges, in a department in which the number and type of Practitioners, or available services, has been limited, as provided by the Bylaws or the Board.

c) Denial of a completed Application for a requested modification of Clinical Privileges, except for the following reasons:

1) The subject Appointee failed to submit a complete Application, a request for modification of specific Clinical Privileges, and all necessary credentialing requirements, without good cause, as required prior to the expiration of any current appointment period;

2) The subject Appointee withdraws a complete Application and request for modification for specific Clinical Privileges due to the failure to document or demonstrate compliance with all credentialing requirements necessary to perform the requested Clinical Privileges; or

3) The subject Appointee seeks modification of specific Clinical Privileges, in a department in which the number and type of Practitioners, or available services, has been limited, as provided by the Bylaws or the Board;

d) Denial of a completed Application for requested modification in Medical Staff category, except for the following reasons:

1) The subject Appointee failed to submit a complete Application, and a request for modification of Medical Staff category, without good cause, as required prior to the expiration of any current appointment period;

2) The subject Appointee withdraws a complete Application and request for modification in Medical Staff category due to the failure to document or demonstrate compliance with all requirements of the specific Medical Staff category; or

3) The subject Appointee seeks modification of Medical Staff category, in a department in which the number and type of Practitioners, or available services, has been limited, as provided by the Bylaws or the Board.

e) Denial of the subject Applicant's written request for reinstatement from leave of absence except for the following reason: The subject Applicant failed to submit a complete request for reinstatement at the conclusion of the leave period.

f) Suspension of Medical Staff membership;

g) Revocation of Medical Staff membership;

h) Denial of requested Clinical Privileges or advancement in Clinical Privileges;

i) Reduction of Clinical Privileges;

j) Suspension or limitation of the right to admit patients or any other restriction related to a Practitioner's suspension of patient care;

k) Suspension of Clinical Privileges, except for the suspension of temporary Clinical Privileges;

l) Revocation or termination of Clinical Privileges; or

m) Other Corrective Action:

1) Which is based on the competence or professional conduct of a Practitioner (which conduct affects or could Adversely Affect the health and welfare of a patient or patients);

2) Which does or may Adversely Affect the Clinical Privileges, the appointment or reappointment to a particular Medical Staff category as appropriate; or

3) Which involves a Practitioner whose continued appointment to the Medical Staff, and Clinical Privileges, is not contingent upon the continuance of a contractual relationship with the Hospital.

n) A Medical Staff Appointee shall not be entitled to any of the hearing or appeal rights or procedures set forth in these Bylaws if any of the following actions are recommended:

1) The appointment of an ad hoc investigation committee;

2) The conduct of an investigation into any matter;

3) The restriction or suspension of an Appointee's Clinical Privileges for a period not longer than fourteen (14) days while an investigation is pending;

4) The formulation and presentation of any preliminary report of an ad hoc investigation committee to the President or Executive Committee;

5) The making of a request or issuance of a directive to an Appointee to appear at an interview or conference before a standing or special committee of the Medical Staff, an ad hoc investigation committee, the Executive Committee, the Board, or any other Medical Staff committee in connection with any investigation prior to a recommended action that Adversely Affects the Appointee's membership or Clinical Privileges;

6) The appointment or subsequent reappointment of an Appointee to the Medical Staff;

7) Automatic Suspension as provided by the Bylaws;

8) The imposition of remedial action, including but not limited to, supervision or observation of a Practitioner's performance, which supervision or observation does not restrict the Clinical Privileges of the Practitioner or the delivery of professional services to patients;

9) The issuance of a letter of warning, admonition or reprimand;

10) Corrective counseling;

11) A recommendation that the Practitioner be directed to obtain retraining, additional training, or continuing education in order to accomplish any of the following objectives:

(a) Improve clinical, or other professional, skills; or

(b) Comply with recently adopted credentialing requirements and/or practice parameters recently adopted by the Medical Staff which result from changes in professional practice or technology, that shall be required as minimum qualifications for the Practitioner's forthcoming application for reappointment or if modification of appointment status or Clinical Privileges is requested;

o) The Practitioner fails to submit a complete request for reinstatement from leave of absence status, and to provide the detailed, written summary of relevant professional activities performed during the leave of absence period, without good cause, at least sixty (60) days prior to the completion of the leave of absence period;

p) The denial of a request for a waiver or reduction of the required minimum liability insurance coverage as provided in the Bylaws;

q) Any recommendation or action that is not determined to be Corrective Action by the Bylaws;

r) A suspension or revocation of temporary Clinical Privileges; or

s) The imposition of the following terms of probation on a Practitioner:

1) Retrospective or concurrent monitoring of a Practitioner's patients and procedures on an ongoing basis, including special consultation or required assistance to perform procedures if this action is not based on the competence or professional conduct of the Practitioner;

2) Required physical examination and reports on the Practitioner by a Physician chosen by the Board or committee thereof; or

t) Required psychological and/or psychiatric examinations and reports on the Practitioner by a Physician chosen by the Board or committee thereof.

ARTICLE 9 – PART B: ENTITLEMENT TO HEARING

An Applicant or an Appointee holding a Medical Staff appointment shall be entitled to a hearing whenever a recommendation unfavorable to such Applicant or Appointee has been made by the Board, Credentials Committee, or other committee regarding those matters enumerated in this Article. The subject Applicant or Appointee shall also be entitled to a hearing, before the Board enters a final decision. Action taken which is not related to the competence or professional conduct of the subject Applicant or Appointee, or falls within the definition of Corrective Action as defined in these Bylaws, shall not be the basis for a hearing (See Article 9, Part A, Section 2, herein). Examples shall include a denial or restriction of Clinical Privileges or denial of Medical Staff appointment because the Hospital has an exclusive arrangement with another individual(s), actions related to nonclinical factors such as the failure to attend Medical Staff meetings, completion of medical records or billing forms and any other matter that does not relate to the competence or professional conduct of the subject Applicant or Appointee. The purpose of the hearing shall be to recommend a course of action to those acting for the Hospital, whether the Medical Staff or Board, and to enumerate the duties and responsibilities of the Hearing Committee and the hearing proceedings. Accordingly, the hearing shall be conducted in as informal a manner as possible, subject only to the rules and procedures set forth in these Bylaws.

ARTICLE 9 – PART C: THE HEARING

Section 1 Time When Recommendation for Corrective Action is Deemed to Have Been Made:

The time when a recommendation for Corrective Action is deemed to have been made is when the Credentials Committee submits its final recommendations to the Executive Committee and any written recommendations to the Board, or the Board otherwise initiates Corrective Action.

Section 2 Special Notice of Preliminary Recommendation for Corrective Action:

a) Special Notice. In the event the Board, Credentials Committee or other committee submits a recommendation for Corrective Action that gives rise to a hearing right,

the Chief Executive Officer shall provide the Practitioner with Special Notice of the following within seven (7) days thereafter:

1) That the Board, Credentials Committee or other committee has recommended that a Corrective Action be taken against the Practitioner and a description of the nature of said recommendation and Corrective Action;

2) The reason(s) for the recommended Corrective Action;

3) As appropriate, that the Practitioner has the right to request a hearing on the proposed Corrective Action;

4) The time limit (of not less than thirty (30) days from the date the Special Notice was mailed by the Hospital) within which the Practitioner must submit a written request for a hearing to the Chief Executive Officer along with a statement that the failure to request a hearing within the said specified time period shall constitute a waiver of rights to a hearing and to the appellate review of the matter;

5) A statement that any higher authority required or permitted to act on the matter following a waiver is not bound by the Adverse Action which the Practitioner has accepted by virtue of the waiver, but may take any action, whether more or less severe, it deems warranted by the circumstances; and

6) A summary of the Practitioner's rights in the hearing.

b) Special Notice for Summary/Automatic Suspension. In the event a Summary or Automatic Suspension is initiated, the Chief Executive Officer shall provide the Practitioner with Special Notice, and if possible, verbal notice of the Summary or Automatic Suspension stating:

1) That a Summary or Automatic Suspension has been taken against the Practitioner;

2) The reason(s) for the Summary or Automatic Suspension; and

3) In the case of a Summary Suspension only:

(a) As appropriate, that the Practitioner has the right to request a hearing on the proposed Corrective Action;

(b) The time limit (of not less than thirty (30) days from the date the Special Notice was mailed by the Hospital) within which the Practitioner must submit a written request for a hearing to the Chief Executive Officer along with a statement that the failure to request a hearing within the said specified time period shall constitute a waiver of rights to a hearing and to the appellate review of the matter;

(c) A statement that any higher authority required or permitted to act on the matter following a waiver is not bound by the Adverse Action which the Practitioner has accepted by virtue of the waiver, but may take any action, whether more or less severe, it deems warranted by the circumstances; and

(d) A summary of the Practitioner's rights in the hearing.

Section 3 Request for or Waiver of Hearing:

a) Request for Hearing. A Practitioner is deemed to have properly requested a hearing within the specific time limit (of not less than thirty (30) days from the date the Special Notice was mailed by the Hospital), if the written request is either delivered personally, or sent by certified mail, return receipt requested, and received by the Chief Executive Officer within thirty (30) days from the date the Special Notice was mailed by the Hospital, and the request includes the following information:

1) The specific request for a hearing;

2) The name and address of the attorney, or other person, if any, that shall represent the Practitioner at the hearing;

3) A list of potential witnesses, if any or known at the time of the request, expected to testify at the hearing on behalf of the Practitioner, and for each witness, a description of their expected testimony; and

4) A list of potential exhibits, if any or known at the time of the request, which the Practitioner expects to present at the hearing.

b) Waiver. A Practitioner is deemed to have waived all rights to a hearing, which shall thereby constitute an implied acceptance of the Corrective Action taken, if:

1) The Chief Executive Officer does not receive written request for a hearing from the Practitioner within thirty (30) days from the date the Special Notice was provided by the Hospital; or

2) The written request fails to include all requested information.

Section 4 Notice of Hearing:

a) Special Notice of Hearing. If a hearing is properly requested on a timely basis, the Practitioner involved must be given Special Notice of the hearing, to include the following information:

1) The location, time, and date of the hearing, which date shall not be less than thirty (30) days after the date the Hospital received the request for hearing;

2) A proposed list of witnesses, if any, expected to testify at the hearing on behalf of the Hospital, and for each witness, a description of their expected testimony;

3) A proposed list of exhibits, if any, which the Hospital expects to present at the hearing;

4) The name of the hearing officer, if one is appointed, or the names of the members of the hearing committee, if one is appointed;

5) Any reports of experts relied upon in formulating the Adverse Action recommendation; and

6) copies of any other documents relied upon by the Peer Review Committees in formulating the Adverse Action recommendation, except for any minutes, other derivative documents, and overall work product from any Peer Review Committee meeting.

b) Special Notice of Hearing for Summary/Automatic Suspension. In the case of a Summary Suspension, if the Practitioner requests an expedited hearing, the Hospital must give the Practitioner Special Notice of the hearing which states:

1) The location, time, and date of the hearing, which date shall not be less than fifteen (15) days after the date the Hospital mailed the Special Notice of the hearing;

2) A list of potential witnesses, if any, expected to testify at the hearing on behalf of the Hospital, and for each witness, a description of their expected testimony;

3) A list of potential exhibits, if any, which the Hospital expects to present at the hearing;

4) The name of the hearing officer, if one is appointed, and the names of the members of the hearing committee, if one is appointed; and

5) Copies of any other documents relied upon by the Peer Review Committees in formulating the recommendation for Summary Suspension, except for any minutes, other derivative documents, and overall work product from any Peer Review Committee meeting.

Section 5 Membership of Hearing Committee:

a) Hearing Committee Options. If a hearing is properly requested by the Practitioner in a timely manner, such hearing shall be held before either:

1) An arbitrator, who is mutually acceptable to the Practitioner and the Hospital;

2) A hearing officer appointed by the Hospital, who shall be a member of the Medical Staff and who is not in direct economic competition with the Practitioner involved or who has actively participated in the recommendation for Corrective Action taken against the Practitioner; or

3) A hearing committee appointed by the Hospital, who shall be members of the Medical Staff, and who are not in direct economic competition with the Practitioner involved or who have actively participated in the recommendation for Corrective Action taken against the Practitioner. The hearing committee shall be composed of not less than three (3) and no more than five (5) members. The Chief Executive Officer shall designate one (1) of the members as the chairperson.

If the parties do not agree to an arbitrator, the Hospital, in its sole discretion, shall decide to appoint a hearing officer or hearing committee.

b) Officials. As part of the Special Notice of the hearing, the Hospital shall also notify the Practitioner of the name(s) of the arbitrator, hearing officer, or hearing committee ("Official(s)");

c) Qualification of Officials. The Practitioner is required to notify the Hospital within ten (10) days after the Special Notice of the hearing was mailed by the Hospital if the Practitioner believes that such Official(s) do not meet the criteria for appointment to the hearing committee, and proof of any actual, not just potential, bias or conflict of interest;

d) Subsequent Notice. In response to any subsequent Special Notice by the Hospital pertaining to the hearing or the Official(s) selected, the Practitioner must repeat the same objection procedures above;

e) Waiver. Failure to advise the Hospital of any such objection to the Official(s) on a timely basis shall be deemed a waiver of any objection to the Official(s) by the Practitioner.

Section 6 Conduct of Hearings:

After the Official(s) have been selected and prior to the hearing:

a) No Ex Parte Communication. Neither the Hospital nor the Practitioner shall have any ex parte communication with the Official(s).

b) Official Statement. The Hospital shall request the Official(s) to submit a written statement to the Hospital that they:

1) Are not in direct economic competition with the Practitioner involved;

2) Will render a fair and impartial decision; and

3) Will avoid any ex parte communication with both the Hospital and the Practitioner involved.

c) Related Materials. The Chief Executive Officer shall provide the Official(s) with copies of the Medical Staff Bylaws, the Rules and Regulations, and any other policies, procedures, resolutions, or otherwise, that relate to the conduct of the hearing.

d) Document Production. Upon request by either the Hospital or the Practitioner, the Official(s) may require the other party to provide information, or produce information, documents, or records in its possession, only after the Official(s) conclude in good faith that the particular information, documents, or records:

1) Are reasonably related to the subject of the hearing;

2) Are not proceedings of, or information, documents, data, or records acquired, generated, or maintained by the Hospital in the exercise of its professional review activities;

3) Are not otherwise available from original sources other than the Hospital; and

4) Are not otherwise deemed confidential or privileged by applicable policies of the Medical Staff, Board or Hospital, or Applicable Regulations or law.

e) Failure to Produce Documents. If the party who is directed to provide such information or documents fails without good cause to do so, the Official(s) shall have wide latitude in drawing adverse inferences against the party who failed to provide the information or documents requested. The Official(s) should consider such refusal and weigh the same in making its recommendation, and any report shall recite the inferences drawn from the refusal to provide any information or documents without good cause, and the reasoning of the Official(s) in drawing such inferences. The party requesting the information or documents shall be given the opportunity to state to the Official(s) what such party believes the information or documents would have shown, if it had been provided as directed by the Official and such statement, if any, shall be made in writing and included as part of the record.

f) Documents Available by Other Means. If the information or documents requested and directed by the Official(s) to be provided are accessible by alternative means, the Official(s) may in their discretion direct that the party refusing to provide such information or documents pay the cost of obtaining the information by such alternative means.

g) Pre-Hearing Conference. Prior to the hearing, the Official(s) shall conduct a pre-hearing conference in order to:

1) Resolve any conflicts concerning the burden of proof, the standard of proof, presentation of evidence, admissibility of evidence, testimony of expert witnesses, opening and closing statements, and the submission of written statements at the close of the hearing;

2) A complete and final copy of all documentary evidence to be submitted by the parties be presented at this pre-hearing conference; any objections to the documents shall be made at that time and the Official(s) shall resolve such objections;

3) the exclusion of certain evidence unrelated to the recommended Corrective Action;

4) A complete and final list of the names of all witnesses and a brief statement of their anticipated testimony be submitted;

5) The time granted to each witness' testimony and cross-examination be agreed upon, or determined by the Official(s), in advance; and

6) The parties agree that any witnesses and documentation not provided and agreed upon in advance of the hearing may be excluded from the hearing unless otherwise approved by the Official(s), in writing.

h) Motions in Limine. Hear any motions in limine, or their equivalent, that may be appropriate, in order to determine the nature and extent of testimony allowed.

i) Failure to Appear. The personal presence of the Practitioner who requested the hearing shall be required. If the Practitioner fails to appear at the hearing without good cause, the Practitioner shall be deemed to have waived such Practitioner's right to a hearing in the same manner and with the same consequences as provided in Article 9, Part C, Section 3, herein.

j) Procedural Rights. During the hearing the Practitioner has the right to:

1) Obtain a record of the proceedings, copies of which may be obtained by the Practitioner upon payment of a reasonable charge;

2) Representation by an attorney, or other person of the Practitioner's choice;

3) Call, examine, and cross-examine witnesses heretofore listed in the Practitioner's request for hearing or subsequent notice;

4) Present evidence determined to be relevant by the arbitrator, hearing officer, or hearing committee (regardless of its admissibility in a court of law); and

5) Submit prior to, during, or at the conclusion of the hearing, a written statement concerning any issue of law or fact for consideration by the Official(s).

k) Moving Party. Whenever a hearing relates to a denial of appointment or reappointment to the Medical Staff, denial of requested Clinical Privileges, or denial of requested modification in Medical Staff appointment or Clinical Privileges, the Practitioner's evidence shall be presented first. In all other cases, the Hospital's evidence shall be presented first:

1) After the first party to present evidence has finished, the opposing party shall present the opposing party's evidence; and

2) The first party shall then have the opportunity to rebut the evidence presented by the opposing party.

l) Opening Statements. The Official(s) may, in their discretion, request or allow opening statements, which if made, shall be presented by the parties in the same sequence as provided for in this presentation of evidence.

m) Burden of Proof. Whenever a hearing relates to a denial of appointment or reappointment to the Medical Staff, denial of requested Clinical Privileges, or denial of requested modification in Medical Staff appointment or Clinical Privileges, the Practitioner shall have the burden of proving, by clear and convincing evidence, that:

1) The Practitioner meets the standards for appointment to the Medical Staff, or the granting of the Clinical Privileges or Medical Staff appointment requested; and

2) The Corrective Action or recommendation for Corrective Action is arbitrary and capricious.

3) In all other cases, the Hospital shall present supporting evidence, but the Practitioner shall have the burden of proving by a preponderance of the evidence, that the proposed recommendation for Corrective Action either:

(a) Lacks any substantial factual basis; or

(b) Is arbitrary and capricious.

n) Evidence. The hearing shall not be conducted according to the Indiana or Federal Rules of Evidence. Hearsay evidence shall not be excluded merely because it constitutes hearsay. The Practitioner shall be permitted to present evidence determined to be relevant, not confidential, or otherwise subject to privilege, by the Official(s), regardless of its admissibility in a court of law. The Official(s) shall permit admission of any evidence which possesses probative value commonly accepted by reasonably prudent persons in the conduct of their affairs.

o) Probative Value. The Official(s) shall have broad discretion in determining whether evidence proposed to be introduced is merely cumulative in nature and does not possess probative value in addition to evidence already admitted, and shall

exclude any such cumulative evidence.

p) Confidentiality and Privilege. The Official(s) shall give effect to the rules of confidentiality and privilege recognized by laws or Applicable Regulations, including but not limited to the privilege for peer review activities, for communications made by a patient to a licensed practitioner of one (1) of the healing arts with reference to any physical or supposed physical disease, or of knowledge gained by such practitioner through a physical examination of a patient made in a professional capacity, as recognized under state and federal law or information determined to be attorney-client privileged. The Official(s) shall also recognize as privileged, to the same extent recognized in judicial proceedings, communications made or documents prepared in anticipation of the hearing (i.e., work product) provided for in this hearing procedure by counsel or otherwise.

q) Objection. Objections to evidentiary offers may be made and shall be noted in the record.

r) Written Form of Evidence. Subject to these requirements, when a hearing shall be expedited and the interests of the parties shall not be prejudiced substantially, any part of the evidence may be received in written form.

s) Additional Evidence. In the event additional allegations or evidence becomes available during the hearing, the Official(s) may allow the parties additional time to prepare a rebuttal or defense to the additional allegations or evidence.

t) Challenges. At the close of the hearing, the Official(s) shall ask the Practitioner to answer the following questions as part of the hearing record, and if any "no" responses, all supporting evidence or reasons:

1) "Do you believe you have received a fair hearing before this arbitrator, hearing officer, or hearing committee?"

2) "Do you believe the Official(s) shall give serious and fair consideration to the evidence you presented during this proceeding?"

3) "Do you believe that no one witness who testified for the Hospital bears any ill will or malice towards you?"

4) "Do you believe that no one member of the Credentials Committee or Executive Committee who recommended this Corrective Action bears any ill will or malice towards you?"

u) Official Notice. In reaching a decision, the Official(s) may take 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 courts of law. 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 an 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 is to be determined by the Official(s). The Official(s) shall also be entitled to consider all other information that can be considered, pursuant to the Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for Clinical Privileges.

v) Record of Hearing.

1) A record of the hearing proceeding shall be recorded either manually or electronically. The cost of the recording shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. Oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in the State of Indiana. The record shall also include a complete copy of all documentary evidence considered by the Official(s) and/or hearing committee.

2) In the event an independent court reporter is employed to record any hearing or proceeding, such reporter shall be instructed on the privileged and confidential nature of the proceedings. If the record of the hearing or proceeding is transcribed, the reporter shall deliver the original and all copies of the transcribed record to the hearing officer for such distribution as the committee may authorize. Upon delivery of the transcribed record to the Official(s), or if the record is not transcribed at the conclusion of the hearing or proceedings, the reporter shall deliver to the Official(s) all documents, memoranda and exhibits presented, including all original shorthand notes, recording tapes or minutes. It is the intent of this section that an independent court reporter shall not retain custody, or a copy thereof, of any document, tape recording, minutes or transcription of the hearing or proceeding.

w) Postponements and Extension. Once a request for hearing is initiated, postponements and extensions of time beyond the time permitted in these Bylaws may be permitted by the Official(s), on a showing of good cause.

x) Presence of Hearing Committee Members and Vote. If a hearing committee is appointed by the Hospital, the majority of the hearing committee must be presented throughout the hearing and deliberations. If a hearing committee member is absent from any part of the proceedings, such hearing committee member shall not be permitted to participate in the deliberations or the decision unless such hearing committee member has consent of each party and has had an opportunity to review the complete record.

y) Adjournment and Conclusion. The Official(s) may adjourn the hearing and reconvene the same without Special Notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious

conclusion to the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if requested, the hearing shall be closed. The Official(s) may recess the hearing until a transcript is prepared for its deliberations.

Section 7 Recommendation and Report of Official(s):

a) The Official(s) shall submit their written report, including a statement of the basis for the recommendation(s), and a copy of the record of the proceedings to the Practitioner and the Hospital, which includes the Executive Committee and the Board, within thirty (30) days following the completion of the hearing. The written report shall contain the following:

1) all applicable findings of fact;

2) whether the findings of fact support, or alternatively, do not support, the allegations and the recommended Corrective Action; and

3) any and all recommended Adverse Action(s), Non-Adverse Action(s), or no action that may be recommended by the Official(s), in lieu of, or in addition to, the original recommended Corrective Action, all for consideration by the Executive Committee.

b) Within thirty (30) days after receipt of the written report of the Official(s), the Executive Committee shall recommend to the Board affirmation, modification, or reversal of the Corrective Action recommended by the Official(s). The Executive Committee shall transmit its recommendation, together with the hearing record, the written report of the Official(s) and all other documentation considered, to the Chief Executive Officer.

c) If the recommendation of the Executive Committee is not averse to the Practitioner, the Chief Executive Officer shall send the recommendation to the Board. The Board shall take action thereon by adopting or rejecting the Executive Committee's recommendation in whole or in part, or by referring the matter back to the Executive Committee for further reconsideration. Any such referral shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action. The Chief Executive Officer shall promptly send the Practitioner Special Notice of each action taken pursuant to this Section. Favorable action by the Board shall become the final decision of the Board, and the matter shall be considered closed.

Section 8 Special Notice of Recommendation and Report of Official(s):

If the recommendation or subsequent recommendation of the Executive Committee is adverse to the Practitioner, the Chief Executive Officer shall promptly give Special Notice to the Practitioner of the recommendation and the Practitioner's right to an appellate review, including:

a) A copy of the recommendation of the Executive Committee; and

b) A reminder that an appellate review before the Board must be requested in writing within twenty (20) days after receipt by the Practitioner of the Special Notice, that a Practitioner under suspension may request an expedited review, that the Practitioner has the right to be represented on appellate review by counsel or a representative of the Practitioner's choice, and that the Practitioner and counsel have the right to appear in person and present oral argument.

Section 9 Request for or Waiver of Appellate Review:

a) A Practitioner shall have twenty (20) days following such Practitioner's receipt of a Special Notice pursuant to Section 8 to file a written request for an appellate review. Such request shall be delivered in person or by certified mail to the Chief Executive Officer or its designee and may include a request for a copy of the report and record of the Official(s) and all other material, favorable or unfavorable, if not previously forwarded, that was considered in making the adverse decision.

b) The request for appellate review shall expressly identify the grounds for appeal and contain a clear concise statement of facts in support of each ground. The grounds for appeal shall include the following:

1) Bias, prejudice, or conflict of interest of the Official(s);

2) The procedure utilized by the Official(s), the Executive Committee, or the Board were unfair and/or unreasonable;

3) Substantial non-compliance with the procedures set forth in the Bylaws or required by Applicable Requirements and applicable state and federal law;

4) The decision was not supported by substantial evidence based upon the hearing record; or

5) The recommended Corrective Action is inappropriate under the circumstances.

c) Failure of any party to request an appellate review in a timely manner shall constitute a waiver of the right to appellate review.

Section 10 Composition of Appellate Review Committee:

a) Membership. The Appellate Review Committee shall consist of no more than three (3) members of the Board, all of whom have submitted written statements to the Hospital that they:

1) Are not in direct economic competition with the Practitioner involved;

2) Were not involved in any vote, consideration, review, or decision-making of any prior recommendation of Corrective Action for Practitioner;

3) Will render a fair and impartial decision; and

4) Will avoid any ex parte communication with both the Hospital and the Practitioner involved.

Section 11 Nature of Appellate Review Proceedings:

The proceedings by the Appellate Review Committee shall be in the nature of an appellate review based upon the record of the hearing before the Official(s), the written report, and all subsequent decisions and actions thereon. The Appellate Review Committee shall also consider the written statements, if any, submitted pursuant to the appeal by the Practitioner. The Appellate Review Committee shall allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions by any member of the Appellate Review Committee.

Section 12 Consideration of New or Additional Matters:

New or additional matters or evidence not raised or presented during the original hearing, or in the Official(s)' recommendations, and not otherwise reflected in the hearing record, shall be introduced during the appellate review process only under unusual circumstances. The Appellate Review Committee, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

Section 13 Report of Appellate Review Committee:

The Appellate Review Committee shall submit its written report, including a statement of the basis for the recommendation(s), to the parties, the Executive Committee, and the Board within fifteen (15) days following the completion of the appellate review. The written report shall contain and confirm whether the final recommended Corrective Action:

a) Is supported by the evidence before the Appellate Review Committee; and

b) If acted upon and approved as a final Corrective Action of the Board, is in the best interest of the Hospital and its patients.

Section 14 Board Action:

a) Review. The Board shall conduct a thorough review of the record, including but not limited to the complaint(s), Request for Corrective Action, investigation, recommendations, and any hearings and appellate review conducted. The purpose of the Board's review is to consider the record for procedural fairness and substantiation of the charges before any final decision is made, regardless of whether a formal appeal was made.

b) Action. The Board has the authority to follow, reject, or modify the recommendation(s) resulting from the investigation conducted by the Investigation Committee, or any hearing or appellate review, to include any of the following actions:

1) If the Practitioner waived, or did not request, a hearing:

(a) Accept the recommendation of the Credentials Committee;

(b) Refer the recommendation back to the Credentials Committee for further consideration; or

(c) Take action contrary to a favorable or unfavorable recommendation of the Credentials Committee;

2) If a hearing was conducted at the request of the Practitioner:

(a) Accept the recommendation of the Official(s), or any appellate review committee;

(b) Refer the recommendation back to the Official(s), or any appellate review committee for further consideration;

(c) Request a de novo hearing; or

(d) Take action contrary to a favorable or unfavorable recommendation of the hearing or appellate review committee.

Section 15 Special Notice of Board Action:

The Practitioner shall receive Special Notice of the Board's final action and a complete statement of the reasons for said action if the action is a Corrective Action within seven (7) days of the Board's action. The final decision of the Board shall be effective immediately and shall not be subject to further review.

Section 16 Exhaustion of Remedies:

Any Practitioner entitled to a hearing and appellate review shall follow and exhaust the remedies afforded by these Bylaws as a prerequisite to any other legal action, if any, available to the Practitioner. Notwithstanding any other provisions contained in these Bylaws, no Practitioner shall be entitled as a matter of right to more than one (1) hearing and one (1) appellate review on any matter which shall have given rise to a hearing right.

Section 17 Subsequent Application or Re-Application:

A Practitioner seeking appointment or re-appointment who has received a final Adverse Action resulting in denial or termination of status, shall not be eligible to re-apply to the Medical Staff for a period of one (1) year, unless the decision itself, or other provisions of these Bylaws,

provide otherwise. Any such re-application shall be processed as an initial application, and the Practitioner shall submit such additional information as the Credentials Committee or the Board may require to demonstrate that the basis for the earlier Adverse Action no longer exists.

Section 18 Board Report to National Practitioner Data Bank:

a) Data Bank Report. When the Board takes any action that qualifies as a Corrective Action, a written report shall be submitted to the Data Bank by the Medical Staff Office and/or the appropriate licensing board(s) pursuant to the requirements set forth in Applicable Regulations and laws.

b) Triggering Events. The written report to the Data Bank shall be made as above, whenever the Hospital:

1) Takes any Corrective Action that Adversely Affects the Practitioner's Medical Staff membership or Clinical Privileges for a period longer than thirty (30) days; or

2) Accepts a Practitioner's surrender of his/her Clinical Privileges:

(a) While the Practitioner is under an investigation by the Hospital relating to possible incompetence or improper professional conduct; or

(b) In return for not conducting such an investigation or proceeding.[1]

c) Summary Suspension. All Summary Suspensions[2] are to be reported to the appropriate licensing board(s) prior to a final action taken by the Board. If the Board should later modify, revise, or reverse the Summary Suspension, the revisions would also be reported to the appropriate licensing board(s).

[1] According to this requirement, once a Practitioner is under investigation that may result in a Corrective Action, any investigations or settlements may become subject to reporting under state or federal law. Therefore, any of the following actions that are accomplished prior to the initiation of an investigation are not subject to reporting requirements under state and federal law:

1. Resolution of issues concerning Practitioner's application for initial appointment or reappointment, or application for modification of Medical Staff appointment or Clinical Privileges;
2. Resolution of issues concerning a pattern of acts, demeanor, or conduct of a Practitioner.

[2] Summary Suspensions that are: (a) in effect and imposed for more than thirty (30) days; (b) are based on the professional competency or professional conduct of the Practitioner that Adversely Affected, or could Adversely Affect the health or welfare of a patient or employee of the Hospital; and (c) are the result of a Corrective Action taken by the Hospital.

ARTICLE 9 – PART D: GENERAL PROVISIONS

Section 1 Release:

By requesting a hearing or appellate review under this Article 9, the subject Practitioner agrees to be bound by the provisions of these Bylaws and applicable policies and procedures, relating to immunity from liability.

Section 2 Confidentiality:

All records, communications, determinations and other information and materials generated in connection with and/or as a result of Peer Review Activity shall be confidential and privileged, and each individual or member of a Peer Review Committee participating in such Peer Review Activity shall agree to make no disclosures of any such information except as authorized in writing, by the chair or president of the applicable Peer Review Committee. Any breach of confidentiality by an individual or member of a Peer Review Committee may result in the loss of federal and/or state immunity afforded to such proceedings and/or Peer Review Activity, and/or may result in appropriate legal action to ensure that confidentiality is preserved, including application to a court of law for injunctive or other relief.

Section 3 Peer Review Protections:

All minutes, reports, recommendations, communications, determinations, and actions made or taken pursuant to this Article 9 are deemed to be covered by the Indiana Peer Review Act, I.C. §34-30-15, *et seq.*, or the corresponding provisions of any subsequent federal or state statute providing immunity and privileges to Peer Review Activity. Furthermore, a Peer Review Committee charged with making reports, findings, recommendations, determinations or investigations pursuant to this Article 9 shall be considered to be acting on behalf of the Hospital and/or the Medical Staff when engaged in such Peer Review Activity, and therefore shall be deemed to be a professional review body as that term is defined in the Health Care Quality Improvement Act of 1986.

ARTICLE 10
RULES AND REGULATIONS OF THE MEDICAL STAFF

Medical Staff Rules and Regulations as may be necessary to implement more specifically the general principles of conduct found in these Bylaws shall be adopted in accordance with this Article. Such Rules and Regulations shall set standards of practice that are to be required of each individual exercising Clinical Privileges in the Hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. The Rules and Regulations of the Medical Staff shall have the same force and effect as the Bylaws.

Particular Rules and Regulations may be adopted, amended, repealed or added by vote of the Executive Committee at any regular or special meeting provided that copies of the proposed amendments, additions or appeals are posted on the Medical Staff bulletin board and made available to all Executive Committee members fourteen (14) days before being voted upon, and further provided that all written comments on the proposed changes by persons holding current appointments to the Medical Staff are brought to the attention of the Executive Committee before the change is voted upon. Changes in the Rules and Regulations shall become effective only when approved by the Board.

Rules and Regulations may also be adopted, amended, repealed or added by the Medical Staff at a regular meeting or special meeting called for that purpose provided that the procedure used in amending the Medical Staff Bylaws is followed. All such changes shall become effective only when approved by the Board.

Proposed changes in the Rules and Regulations may also be referred to the Bylaws Committee, by the Executive Committee, a department, another committee, or the Medical Staff. The Bylaws Committee, following discussion and consideration of the proposed changes, will then make a report to the Executive Committee (including recommendations regarding the proposed changes), as provided in Article 6 of these Bylaws. The Executive Committee shall then proceed as described in this Article above.

ARTICLE 11
BYLAWS NOT A CONTRACT; AMENDMENTS

These Bylaws shall not be deemed as a contract of any kind between the Board and the Medical Staff or any individual Member thereof. Applications for, the conditions of, and the duration of appointment to the Medical Staff shall not be deemed contractual in nature because the continuance of any such Clinical Privilege with this Hospital is based solely upon an individual's continued ability to justify the exercise of such Clinical Privileges and do not obligate the individual to practice at the Hospital. The Board is obligated to use essential fairness in dealing with Medical Staff Applicants and Appointees, and may fulfill that obligation by following the procedure specified in these Bylaws or any other procedures which are fair in the circumstances.

All proposed amendments of the Bylaws initiated by the Medical Staff shall, as a matter of procedure, be referred initially to the Executive Committee. After discussion, the Executive Committee shall then refer those proposed amendments which the Executive Committee feels need further discussion and/or research to the Bylaws Committee (as provided in Article 6 of these Bylaws). Following initial consideration, or following review of the recommendations of the Bylaws Committee, the Executive Committee shall report 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. They shall be voted upon at that meeting, provided that they shall have been posted on the Medical Staff bulletin board at least fourteen (14) days prior to the meeting. To be adopted, an amendment must receive a majority of the votes cast by the Active Members of the Medical Staff who are present at the time of such vote and who are eligible to vote. Amendments so adopted shall be effective when approved by the Board.

The Executive Committee shall have the power to adopt such amendments to the Bylaws, Rules and Regulations as are, in the Executive Committee's judgment, technical or legal modifications or clarifications, changes necessary to comply with law or regulation, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board within sixty (60) days of adoption by the Executive Committee. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Executive Committee. Immediately upon adoption, such amendments shall be sent to the Chief Executive Officer and posted on the Medical Staff bulletin board for fourteen (14) days.

These Bylaws (as well as the Medical Staff Rules and Regulations) should be reviewed at least every three (3) years or more often if the need arises by the Bylaws Committee, as outlined in Article 6 of these Bylaws, and a report should be made to the Executive Committee regarding this review and any recommendations. Recommended amendments or revisions, if any, should then be processed by the Executive Committee as described in this Article above.

Alternate Pathway for Medical Staff to Amend Bylaws to the Board. At the Medical Staff's annual meeting, the Medical Staff may propose a change to the Bylaws, Rules and Regulations, or policies and procedures directly to the Board. That recommendation must have a motion, a second, and a favorable vote from the majority of the voting Members present for the recommendation to go forward. Following the annual meeting, the recommendation must be submitted in writing, by

way of a ballot, to the all voting Members of the Medical Staff for approval. For the recommendation to be approved, a majority of the voting Members must approve the recommendation. The proposed amendment submitted/approved by this method, will be presented to the President of the Medical Staff who will then present the proposal directly to the Board.

ARTICLE 12
ADOPTION

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, and henceforth all activities and actions of the Medical Staff and of each individual exercising Clinical Privileges in the Hospital shall be taken under and pursuant to the requirements of these Bylaws.

The present Rules and Regulations of the Medical Staff are hereby re-adopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws.

APPROVED BY THE MEDICAL STAFF on
September 26, 2023

APPROVED BY THE BOARD OF DIRECTORS
October 5, 2023