CREDENTIALING MANUAL

A MANUAL OF THE MEDICAL STAFF BYLAWS

OF

Hendricks Regional Health

Approved by the Medical Executive Committee: 04/10/2023

Approved by the Board of Trustees: 04/17/2023

Accredited by the Healthcare Facilities Accreditation Program (HFAP)

TABLE OF CONTENTS

PREAMBLE 4

DEFINITIONS 4

ARTICLE I MEDICAL STAFF CATEGORIES 7

1.1 ACTIVE STAFF 7
1.2 COURTESY STAFF 7
1.3 HONORARY STAFF 8
1.4 AFFILIATE STAFF 8
1.5 TELEMEDICINE STAFF 9

ARTICLE II INITIAL APPOINTMENT 10

2.1 QUALIFICATIONS FOR APPOINTMENT 10
2.2 WAIYER OF BOARD CERTIFICATION REQUIREMENT 11
2.3 NO ENTITLEMENT TO APPOINTMENT 12
2.4 NON-DISCRIMINATION POLICY 12
2.5 ETHICAL AND RELIGIOUS DIRECTIVES 12
2.6 CONDITIONS OF APPOINTMENT 12

ARTICLE III APPLICATION PROCESS 13

3.1 INFORMATION 13
3.2 BASIC RESPONSIBILITIES OF APPLICANTS AND MEMBERS 15
3.3 BURDEN OF PROVIDING INFORMATION 17
3.4 AUTHORIZATION TO 0BTAIN INFORMATION 17
3.5 PROCEDURE FOR APPOINTMENT 18

ARTICLE IV REAPPOINTMENT 21

4.1 PROCEDURE FOR REAPPOINTMENT 21
4.2 DEPARTMENT CHAIRPERSON PROCEDURE 23
4.3 CREDENTIALS COMMITTEE PROCEDURE 23
4.4 MEC PROCEDURE 23
4.5 BOARD PROCEDURE 23

ARTICLE V CLINICAL PRIVILEGES 23

5.1 EXERCISE OF CLINICAL PRIVILEGES FOR PHYSICIANS, DENTISTS, AND PODIATRISTS 23
5.2 CLINICAL PRIVILEGES FOR DENTISTS 25
5.3 CLINICAL PRIVILEGES FOR PODIATRISTS 25
5.4 VOLUNTARY RELINQUISHMENT OF PRIVILEGES 26
5.5 TEMPORARY CLINICAL PRIVILEGES 27
5.6 EMERGENCY CLINICAL PRIVILEGES 29
5.7 PROCEDURE FOR REQUESTING ADDITIONAL CLINICAL PRIVILEGES 30
5.8 MEDICAL STAFF MEMBER RESPONSIBILITY FOR MAINTENANCE OF CREDENTIAL FILE 31

ARTICLE VI PRIVILEGES FOR NEW PROCEDURES AND NEW TECHNOLOGY 32

6.1 REQUESTS FOR CLINICAL PRIVILEGES FOR NEW PROCEDURES AND NEW TECHNOLOGY 32

ARTICLE VII PROCEDURE FOR LEAVE OF ABSENCE 33

7.1 REQUESTS FOR LEAVE OF ABSENCE 33
7.2 PROCEDURE FOR REVIEW OF REQUESTS FOR LEAVE OF ABSENCE 33
7.3 REQUESTS FOR REINSTATEMENT 33
7.4 ABSENCE FOR LONGER THAN ONE (1) YEAR 34

7.5 NO ENTITLEMENT TO LEAVES OF ABSENCE OR REINSTATEMENT ... 34

ARTICLE VIII TELEMEDICINE ... 34

8.1 TELEMEDICINE PRIVILEGES ... 34

ARTICLE IX EDUCATIONAL STAFF ... 35

9.1 EDUCATIONAL STAFF ... 35

ARTICLE X ALLIED HEALTH PROFESSIONALS ... 36

10.1 CATEGORIES OF ALLIED HEALTH PROFESSIONALS ... 36
10.2 ELIGIBILITY ... 37
10.3 APPLICATION FOR CLINICAL PRIVILEGES ... 40
10.4 CREDENTIALING PROCEDURE ... 42
10.5 RE-CREDENTIALING ... 43
10.6 CORRECTIVE ACTION ... 43

ARTICLE XI AMENDMENT ... 44

11.1 AMENDMENT ... 44
11.2 RESPONSIBILITIES AND AUTHORITY ... 44
11.3 ORIGINATION ... 45

ARTICLE XII ADOPTION ... 45

12.1 MEDICAL STAFF ... 45
12.2 BOARD ... 45

PREAMBLE

As set forth in the Medical Staff Bylaws, no Physician, Dentist or Allied Health Professional shall admit or provide medical or health-related services to patients in the Hospital unless he or she has been duly granted Membership and Clinical Privileges, as applicable, pursuant to the Medical Staff Bylaws and this Credentialing Manual. The requirements, qualifications, and procedures for appointment and reappointment to the Medical Staff and granting of Clinical Privileges are set forth in Medical Staff Bylaws and this Credentialing Manual. Membership on the Medical Staff constitutes neither an employee nor independent contractor relationship with the Hospital unless such a relationship is separately established directly between the Hospital with a Member of the Medical Staff or Allied Health Professional through a contractual arrangement. In the event of any conflict between the Medical Staff Bylaws, this Credentialing Manual or the Corrective Action and Fair Hearing Plan and a specific contractual arrangement between the Hospital and a Member or Allied Health Professional, the language of the contractual arrangement will control.

Clinical Privileges granted to Members or Allied Health Professionals shall be determined by the Board of Directors, in accordance with the Medical Staff Bylaws and this Credentialing Manual. All determinations regarding the granting or denial of Clinical Privileges shall be based upon the written criteria established by the Board for the granting of Clinical Privileges within each Department of the Hospital as further outlined in the Medical Staff Bylaws, this Credentialing Manual, and applicable Department charter or policy.

DEFINITIONS

The following definitions apply to the Bylaws and this Credentialing Manual. The use of capitalization when defining terms is intended for convenience purposes only and shall not affect the meaning or interpretation of such terms throughout these Bylaws.

AHP or ALLIED HEALTH PROFESSIONAL means any individually licensed or certified health care provider who is not a Physician or Dentist, who has an independent or dependent scope of practice, and who may qualify to exercise specified Clinical Privileges within the Hospital. Upon the granting of Clinical Privileges, AHPs are not Members of the Medical Staff. Because AHPs are not Members of the Medical Staff, the procedural rights afforded to AHPs who have been granted Clinical Privileges are set forth in this Credentialing Manual and not in the Corrective Action and Fair Hearing Plan.

APPLICANT means any individually licensed or certified health care provider, including Physicians, Dentists and AHPs, who is applying for Membership on the Medical Staff, Clinical Privileges or permission to provide health care services as appropriate at the Hospital.

BOARD shall mean the Board of Directors of Hendricks Regional Health which has the overall responsibility for the conduct and performance of the Hospital

CEO means the individual appointed by the Board of Directors to act as President and Chief Executive Officer of the Hospital with the delegated responsibility of overall management of the Hospital and its operations.

CLINICAL PRIVILEGES mean Board-granted privileges, permission, and other circumstances by which Members and AHPs may furnish medical care or other patient care services to patients at the Hospital and to utilize Hospital resources necessary to provide such services.

DENTISTS mean individuals who are licensed to practice dentistry in the State of Indiana, who are subject to the Health Care Quality Improvement Act of 1986, and who are Members of, or Applicants to, the Medical Staff.

EMERGENCY PRIVILEGES means those duly granted clinical privileges granted to health care providers upon the occurrence of an emergency as more fully described in this Credentialing Manual.

GOOD STANDING means being under no form of suspension or restriction of any kind regarding Medical Staff appointment or Clinical Privileges at the Hospital and/or at any other health care facility or organization.

HOSPITAL means Hendricks Regional Health

HOSPITAL ADMINISTRATION means the executive administrative leadership of the Hospital consisting of the CEO, Chief Financial Officer, Legal Counsel, Chief Operating Officer, Chief Nursing Officer, Chief Medical Officer and their respective administrative staff.

HOSPITAL BYLAWS shall refer to the Governing Bylaws Hendricks Community Hospital which operates as Hendricks Regional Health

MEDICAL EXECUTIVE COMMITTEE or MEC means the Medical Staff Executive Committee.

MEDICAL STAFF or STAFF means all Physicians and Dentists who are duly appointed by the Board as Members of the Medical Staff.

MEDICAL STAFF BYLAWS or BYLAWS shall refer to the Medical Staff Bylaws and Related Manuals of Hendricks Regional Health, as duly approved by its Medical Staff and Board, and as more fully described in such documents.

MEMBER means any Physician or Dentist who has been duly appointed by the Board as a Member of the Medical Staff.

MEMBERSHIP means to have the duly appointed status of being a Member of the Medical Staff of Hendricks Regional Health

NUMBER OF DAYS or DAYS means "calendar days" (i.e. including Saturday, Sunday, and legal holidays) unless the 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.

PEER REVIEW COMMITTEE or PROFESSIONAL REVIEW BODY means the Board, the MEC, the Physician Relations Committee, any committee of the Medical Staff or Board or their designated personnel and agents having the responsibility for evaluation, recommendation or making a determination concerning qualifications of a professional health care provider, patient care rendered by a professional health care provider or the merits of a complaint against a professional health care provider. Peer Review Committee or

Professional Review Body functions shall include the review of competence and professional conduct of professional health care providers leading to determinations concerning the granting of Clinical Privileges or Medical Staff Membership, the scope and condition of such Clinical Privileges or Membership, and the modification of such Clinical Privileges or Membership.

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.

PHYSICIANS means doctors of medicine and osteopathy who are licensed to practice medicine in the State of Indiana, who are subject to the Federal Health Care Quality Improvement Act of 1986, and who are Members of, or Applicants to, the Medical Staff.

PODIATRISTS means individuals who are licensed to practice podiatry in the State of Indiana and who are Members of, or Applicants to, the Allied Health Staff.

CHIEF OF STAFF means the individual duly elected by the Medical Staff to serve as the primary elected Medical Staff officer to the hospital holding the responsibilities and obligations of Medical Staff Representative.

RELATED MANUALS means those manuals that are a part of the Medical Staff Bylaws to include this Credentialing Manual, the Corrective Action and Fair Hearing Plan, and the Medical Staff Rules and Regulations.

SPECIAL NOTICE means written and/or electronic notification sent by certified or registered mail, return receipt requested and/or personally delivered by hand. All requests, statements and other communications made by Special Notice shall be copied to the Chief of Staff, CMO, and the CEO.

TEMPORARY CLINICAL PRIVILEGES means those clinical privileges granted to health care providers on a non-routine, temporary basis when related to certain circumstances involving important patient care needs, credentialing delays, and locum tenens arrangements as more fully described in this Credentialing Manual.

CHIEF MEDICAL OFFICER means the individual serving as the Medical Staff liaison officer of Hospital Administration. He or she assists with coordination of the Medical Staff's performance improvement and quality assurance activities, Hospital Administration - Medical Staff liaison functions, and the clinical organization of the Medical Staff.

Words used in this Credentialing Manual shall be read interchangeability as the masculine or feminine 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 this Credentialing Manual.

ARTICLE I

MEDICAL STAFF CATEGORIES

The Medical Staff of Hendricks Regional Health is comprised of the following categories:

1.1 Active Medical Staff

1.1-1 Qualifications

The Active Staff shall consist of those Physicians and Dentists who meet the qualifications set forth in Article II below, who attend, admit or are involved in the treatment of more than twenty-five (25) inpatients, outpatients, and/or procedures per calendar year at the Hospital.

1.1-2 Responsibilities

Each Member of the Active Staff shall:

(a) Assume all the functions and responsibilities of appointment to the Active Staff, including care for unassigned patients, emergency service care, consultation and teaching assignments.

(b) Participate in performance improvement and monitoring activities including evaluating Members, as assigned by Department or Committee Chairpersons and the President of the Medical Staff.

1.1-3 Prerogatives

Members of the Active Staff in good standing shall be entitled to vote and hold office without restriction.

1.2 Affiliate Staff Category

1.2-1 Qualifications

The Affiliate Staff shall consist of Physicians and Dentists who meet the qualifications set forth in Article II below, but who do not wish to assume all the responsibilities and prerogatives of appointment to the Active Staff, except as assigned from time to time. Affiliate Staff may provide no more than twenty-five (25) patient admissions, procedures, or face to face patient encounters at the Hospital or Hospital facilities per calendar year, except where the Member can demonstrate that the excess volume occurred as a result of temporary assignment or because of a unique set of circumstances unlikely to reoccur.

1.2-2 Responsibilities

Each Member of the Affiliate Staff shall assume responsibility for care of unassigned patients, emergency service care, consultation and teaching assignments, and other responsibilities as assigned by their respective Department Chairperson within the scope of granted Clinical Privileges.

1.2-3 Prerogatives

Affiliate Staff are encouraged to attend Medical Staff and Department meetings. Members of the Affiliate Staff shall not have Medical Staff committee responsibilities, may not vote and may not hold office.

1.3 Honorary Staff

1.3-1 Qualifications

Honorary Staff shall consist of Physicians and Dentists who have retired from an active medical practice and at the time of their retirement were Members in good standing of the Medical Staff with an outstanding reputation. Honorary Staff may be selected for special assignments at the Hospital. Honorary Staff are not required to meet and maintain the qualifications of Section 2.1 herein.

1.3-2 Responsibilities

Each Member of the Honorary Staff shall assume only those responsibilities obtained through special assignment and as assigned by the President of the Medical Staff.

1.3-3 Prerogatives

Honorary Staff may attend Medical Staff meetings and educational programs. Honorary Staff are not required to apply for reappointment nor shall they be assessed Medical Staff dues. Members appointed to Honorary Staff shall not be eligible for Clinical Privileges, to vote, to hold office or to serve on Medical Staff committees, unless by appointment of the President of the Medical Staff.

1.4 Telemedicine Staff

1.5-1 Qualifications

Any Member in good standing may provide services and care for patients in the Hospital via telemedicine link. The category of Telemedicine Staff is intended for those Applicants or Members who routinely or totally provide health care services via telemedicine link. Telemedicine Staff:

(a) Do not otherwise qualify as Members of the Active Staff but who meet the general qualifications set forth in Section 2.1. If permitted by applicable state and federal law and accreditations requirements, the MEC may make an exception to these general qualifications for an out-of-state Physician if the Physician is otherwise deemed qualified by the MEC;

(b) Possess appropriate clinical and professional expertise;

(c) Are willing and able to schedule or appropriately respond when requested to render clinical services within their area of competence; and

(d) Demonstrate active participation in the active or similar medical staff category of another hospital or otherwise be eligible for such participation.

1.5-2 Responsibilities

(a) Each Member of the Telemedicine Staff may assume only those responsibilities assigned by the President of the Medical Staff.

1.5-3 Prerogatives

Telemedicine Staff shall be entitled to:

(a) Exercise such Clinical Privileges as are granted pursuant to Section 8.1;

(b) Attend meetings of the Medical Staff, including open committee meetings, but shall have no right to vote at such meetings; and

(c) Telemedicine Staff Members shall not be eligible to hold office in the Medical Staff organization nor serve on Medical Staff committees.

1.5-4 Appointment and Reappointment

The appointment and reappointment to the Telemedicine Staff shall be made and evaluated pursuant to Article II and IV herein.

ARTICLE II

INITIAL APPOINTMENT

2.1 Qualifications for Appointment

2.1-1 Basic Qualifications

Appointment to the Medical Staff is a privilege that shall be extended only to professionally competent Physicians and Dentists who initially and continuously meet the qualifications, standards, and requirements set forth in the Bylaws and this Credentialing Manual and such other policies as are adopted from time to time by the Board. All Physicians and Dentists, practicing medicine and dentistry, in the Hospital, unless granted Clinical Privileges for emergency or temporary purposes, must first be appointed as Members of the Medical Staff. Appointment, if granted by the Board, shall be for a period of not more than two (2) years.

Only Physicians and Dentists who satisfy the following threshold qualifications shall be qualified to receive an application for initial appointment to the Medical Staff:

(a) possess a current, unlimited license to practice medicine in the State of Indiana, including DEA and CSR. Pathologists and Teleradiologists are exempt from the DEA and CSR requirement;

(b) are located within the Hospital's geographic service area (as may be defined from time to time by the Board) and within sufficient proximity to the Hospital to provide continuous and timely care for Hospital patients;

(c) possess current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Hospital and to qualify and maintain status as a health care provider under Indiana Medical Malpractice Act;

(d) have successfully completed an accredited ACGME/NCFMEA residency training program in the specialty in which the Applicant seeks Clinical Privileges;

(e) are either certified by the appropriate specialty board or admissible for examination for certification by the American Board of Medical Specialties or an approved American Osteopathic Board, in the area in which privileges are requested, and thereafter certified within five (5) years of initial Staff appointment, unless such requirement is waived by the Board after considering the specific competence, training, and experience of the individual in question or waived by the Board for those Applicants and Members who practice in medical subspecialties where there are specific practice prerequisites for admissibility to board examination:

1) Dentist Applicants and Members requesting surgical Clinical Privileges must be certified or admissible to examination for certification by the American Board of Oral and Maxillofacial Surgery; and

(f) have satisfactorily completed a minimum of fifty (50) Level 1 CMEs (as defined by the AMA PRA Category I – same as AOA Category 1-A) during the preceding two (2) years prior to application (not applicable to Applicants who have graduated from a residency program within the past two (2) years); and

(g) can demonstrate to the satisfaction of the MEC the necessary:

1) background, education, experience, training, and demonstrated competence;

2) adherence to the ethics of their profession;

3) good reputation and character, including the Applicant's physical and mental health and emotional health

4) evidence of 2 MMR vaccines (or adequate vaccine records or adequate titers); 2 Varicella (or adequate vaccine records or adequate titers); Tdap (current within the last 10 years); Hep B vaccination series; Hep A vaccination series; UDS; Flu Vaccine; Covid-19 vaccination

5) the ability to work harmoniously with others, all of which with sufficient adequacy to assure the Medical Staff that any patient treated by the Applicant in the Hospital will be provided quality medical care and that the Hospital and Medical Staff will be able to operate in an orderly and effective manner.

2.2 Waiver of Board Certification Requirement

2.2-1 Applicants for appointment to the Medical Staff and Members seeking reappointment may request that the board certification or admissibility requirement be waived. When such a request is made, the Applicant shall bear the burden of demonstrating that his or her education, training, experience, and competence are equivalent to the Hospital's board certification or admissibility requirement. The Applicant's quality record at the Hospital must be based upon sufficient volume of activity to permit an appropriate and valid determination. The Applicant's request shall be evaluated based upon past professional performance as well as any relevant and pertinent information which might influence the Applicant's performance. The Board may grant a waiver after considering the findings of the Physician Relations Committee, MEC or any other committee designated or authorized by the Board to evaluate such matters.

2.2-2 A decision by the Board to deny the request for a waiver does not entitle an Applicant to a fair hearing or appellate review as provided for in the Corrective Action and Fair Hearing Plan.

2.2-3 Granting a waiver by the Board shall not be construed or deemed to establish a precedent for any other case concerning the matter of board certification.

•

2.2-4 Waiver of board certification requirement by the Board may be granted in only those rare circumstances and then only when such action is deemed by the Board to be of extraordinary benefit to the Hospital and/or the patient population that it serves.

2.2-5 Board Certification (MOC) can be used in lieu of the requirement to provide 50 Category 1 CME credit hours.

2.3 No Entitlement to Appointment

2.3-1 No individual shall be entitled to appointment to the Medical Staff or the exercise of specified Clinical Privileges in the Hospital merely by virtue of the fact that such individual:

(a) is licensed to practice a profession in this or any other state;

(b) is a member of any particular professional organization;

(c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility; or

(d) resides in the geographic service area of the Hospital as defined by the Board.

2.4 Non-Discrimination Policy

No individual shall be denied Medical Staff appointment or Clinical Privileges on the basis of sex, race, creed, religion, color, national origin, handicap or on the basis of any criteria unrelated to the delivery of quality patient care at the Hospital, to professional qualifications or to the Hospital's purposes, needs and capabilities.

2.5 Conditions of Appointment

2.6-1 Duties of Members

Appointment to the Medical Staff requires each Member to assume such reasonable duties and responsibilities as the Medical Staff or the Board shall require. Each Member agrees to provide the clinical services for which he or she is privileged at Hendricks Regional Health.

2.6-2 Professional Conduct

All Members of the Medical Staff are expected to relate in a positive and professional manner to other health care professionals within the Hospital, and to cooperate and work collegially with Medical Staff leadership and Hospital Administration, management, and personnel.

ARTICLE III

APPLICATION PROCESS

3.1 Information

3.1-1 Applications for appointment to the Medical Staff shall be in writing or electronically submitted on forms approved by the Board upon recommendation of the Physician Relations Committee. These forms shall be obtained from the Medical Staff Office.

3.1-2 The application shall contain a request for specific Clinical Privileges desired by the Applicant and shall require detailed information concerning the Applicant's professional qualifications and experience including:

(a) the names and complete addresses of at least two (2) Physicians and Dentists, as appropriate, who have had recent extensive experience in observing and working with the Applicant, and who can provide adequate information pertaining to the Applicant's present professional competence and character. These references may not be from individuals associated or about to be associated with the Applicant in professional practice or personally related to the Applicant. At least one (1) reference shall be from the same specialty area as the Applicant;

(b) the names and complete addresses of the chairpersons of each department of all hospitals or other health care institutions at which the Applicant has worked or trained *(i.e.,* the individuals who served as chief or chairperson at the time the Applicant worked in the particular Department);

(c) information as to whether the Applicant's medical staff appointment or clinical privileges have ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced or not renewed at any other hospital or health care facility;

(d) information as to whether the Applicant has ever voluntarily or involuntarily withdrawn his/her application for appointment, reappointment, and clinical privileges, or resigned from the medical staff or from employment before final decision by a hospital's or health care facility's governing board;

(e) information as to whether the Applicant's license to practice any profession in any state, or Drug Enforcement Administration/Controlled Substance Registration license is or has ever been suspended, modified, terminated, restricted or is currently being challenged. (The submitted application shall include a list or copy and verification of all the Applicant's current licenses to practice, as well as copies of DEA, CSR, medical, dental, or podiatric school diploma, and certificates from all post graduate training programs completed);

(f) information as to whether the Applicant has current professional liability insurance coverage which covers the Clinical Privileges the Applicant or Member seeks to exercise at the Hospital. The Applicant must meet participation requirements and qualified health care provider status of the Indiana Medical Malpractice Act;

(g) a consent to the release of information from the Applicant's present and past professional liability insurance carriers;

(h) information concerning the Applicant's professional litigation experience, specifically information concerning pending claims, final judgments or settlements: (i) the substance of the allegations, (ii) the findings, (iii) the ultimate disposition, and (iv) any additional information concerning such proceedings or actions as the Credentials Committee or the Board may deem appropriate;

(i) information concerning any professional misconduct proceedings and any malpractice actions involving the Applicant in this state or any other state, whether such proceedings are closed or still pending;

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

(k) information regarding the Applicant's current physical, emotional, and mental health status;

(I) information as to whether the Applicant has ever been convicted of, plead guilty or no contest, or whether charges are pending with regard to a violation of a federal, state, or local law relating to the use, manufacturing, distribution, or dispensing of controlled substances, or any offense, misdemeanor, or felony in any state with details about any such instance;

(m) a complete chronological listing of the Applicant's professional and educational appointments, employment, or positions;

(n) information on the citizenship and/or visa status of the Applicant;

(o) the Applicant's signature; and

(p) such other information as the Board or Medical Staff may require.

3.1-3 The history of malpractice verdicts and the settlement of malpractice claims, as well as pending claims, will be evaluated as a criterion for appointment, reappointment, and the granting of Clinical Privileges. However, the mere presence of verdicts, settlements or claims shall not, in and of themselves, be sufficient to deny appointment or particular Clinical Privileges. The evaluation shall consider the extent to which verdicts, settlements, or claims evidence a pattern of care that raises questions concerning the individual's clinical competence, or whether a verdict, settlement, or claim in and of itself, represents such deviation from standard medical practice as to raise overall questions regarding the Applicant's clinical competence, skill in the particular clinical privilege or general behavior.

3.2 Basic Responsibilities of Applicants and Members

3.2-1 The following basic responsibilities and representations shall be applicable to every Applicant for appointment and Member for reappointment as a condition of consideration for their application and as a condition of continued Membership if granted:

(a) an obligation to provide appropriate continuous care and supervision to all patients within the Hospital for whom the individual has responsibility;

(b) an agreement to abide by all Hospital policies, including the Hospital Bylaws and Medical Staff Bylaws and Related Manuals;

(c) an agreement to accept Medical Staff committee assignments and such other reasonable duties and responsibilities as shall be assigned;

(d) an agreement to provide to the Hospital, with or without request, and, as it occurs, new or updated information that is pertinent to any question on the application form;

(e) a statement that the Applicant has received or otherwise had an opportunity to review a copy of the Hospital Bylaws and the Medical Staff Bylaws and Related Manuals, and that the Applicant has agreed to be bound by the terms thereof in all matters relating to consideration of the application without regard to whether appointment to the Medical Staff and/or Clinical Privileges are granted;

(f) a statement of the Applicant's willingness to appear for personal interviews in regard to the application;

(g) a statement that any misrepresentation, misstatement, or omission from the application, whether intentional or not, shall constitute cause for automatic and immediate rejection of the application on administrative grounds;

(h) an obligation to use the Hospital and its facilities sufficiently to allow the Hospital, through assessment by appropriate Medical Staff committees and Department Chairpersons, to evaluate in a continuing manner the current competence of the Member;

(i) an agreement that the hearing and appeal procedures set forth in the Corrective Action and Fair Hearing Plan shall be the sole and exclusive remedy with respect to any Professional Review Action taken at this Hospital;

(j) an agreement to abide by all emergency service call policies of the Hospital and Medical Staff, including the Bylaws and Related Manuals, and such other reasonable duties and responsibilities as assigned. This agreement includes an acknowledgement that a failure to abide by such policies is subject to enforcement and/or disciplinary action under the Corrective Action and Fair Hearing Plan.

3.2-2 The following requirements shall be applicable to every Applicant and Member as a condition of consideration of their application, and as a condition of continued Membership, if granted:

(a) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(b) to refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;

(c) to refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;

(d) to seek consultation whenever medically appropriate or necessary;

(e) to promptly notify the CEO or a designee, CMO and the Medical Staff Office of any change in eligibility with third-party payers or for participation in governmental health care programs, including Medicare and Medicaid, and any sanctions imposed or recommended by the U.S. Department of Health and Human Services, and/or the receipt of a professional review organization citation and/or quality denial letter concerning alleged quality problems in patient care;

(f) to abide by the Medical Staffs Code of Conduct and generally recognized ethical principles applicable to the Applicant's or Member's profession;

(g) to participate in the monitoring and evaluation activities of clinical Departments;

(h) to complete in a timely manner the medical and other required records for all patients as required by the Medical Staff Bylaws and Related Manuals, and other applicable policies of the Hospital;

(i) to work cooperatively with Members, AHPs, nursing staff and other Hospital personnel so as not to adversely affect patient care and disrupt Hospital and Medical Staff operations;

(j) to promptly pay any applicable Medical Staff dues and assessments;

(k) to participate in continuing medical education programs in order to maintain proficiency and competency for the benefit of the Applicant or Member and for the benefit of other professionals and Hospital personnel. A minimum of fifty (50) Level 1 CMEs are required during each two (2) year appointment period or verification of continued Board Certification (MOC);

(l) to authorize the release of all information necessary for an evaluation of the individual's qualifications for initial or continued appointment, reappointment, and/or Clinical Privileges;

(m) to agree hold harmless and release the Hospital, its officers, directors or trustees, 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, reappointment or Clinical Privileges; and

(n) to extend to and recognize immunity for the Hospital, its Medical Staff, and all individuals acting by or for the Hospital and/or its Medical Staff for all matters relating to Professional Review Actions, including appointment, reappointment, and assessment for Clinical Privileges or the individual's qualifications for the same, to the fullest extent as provided for under federal and state law

3.2-3 Each Applicant and Member expressly agrees to these foregoing responsibilities and requirements as conditions of appointment and continuing Membership.

3.3 Burden of Providing Information

3.3-1 The Applicant shall have the burden of producing adequate information for a proper evaluation of background, competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications to the satisfaction of the MEC and Board.

3.3.2 The Applicant shall have the burden of providing evidence that all the statements made and information given on the application are true and correct.

3.3-3 Until the Applicant has provided all information requested by the Medical Staff, MEC, and Board, all applications for appointment, reappointment, and Clinical Privileges will be deemed incomplete and will not be processed. If information provided in an initial application for appointment changes during the course of an appointment year, the Applicant or Member has the burden to provide information about such change to the Physician Relations Committee sufficient for the Physician Relations Committee's review and assessment.

3.4 Authorization to Obtain Information

The following statements and representations shall be included on each application and form a part of this Credentialing Manual. Each is an express condition applicable to all Applicants, Members, and to all others having or seeking Clinical Privileges at the Hospital. By applying for appointment, reappointment or Clinical Privileges, the Applicant expressly accepts these conditions during the processing and consideration of the application, whether or not appointment or Clinical Privileges are granted. This acceptance also applies during the time of any appointment or reappointment.

3.4-1 Immunity

By submitting an application for appointment or reappointment and to the fullest extent permitted by applicable federal and state law, each Applicant and Member releases from any and all liability, and recognizes and extends immunity to the Medical Staff and Hospital, their Peer Review Committees, authorized representatives, including directors, trustees, officers, staff, employees, personnel and agents, with respect to any acts, communications, documents, recommendations or disclosures involving the Applicant or Member and that concern the following:

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

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

(c) proceedings for suspension or reduction of Clinical Privileges or for revocation of Medical Staff appointment or any other disciplinary sanction;

(d) investigative suspensions;

(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) matters or inquiries concerning the Applicant's or Member's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and/or

(j) any other matter that might directly or indirectly relate to the Applicant's or Member's competence, to patient care or to the orderly operation of this or any other hospital or health care facility.

3.4-2 Authorization to Obtain Information

The Applicant or Member specifically authorizes the Hospital and its authorized representatives to consult or inquire with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, background, ethics, behavior or any other matter reasonably having a bearing on the Applicant's or Member's satisfaction of the criteria for initial and continued appointment to the Medical Staff and Clinical Privileges. 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. Applicants and Members also specifically authorize such third parties to release any relevant information to the Medical Staff and Hospital and their authorized representatives upon request.

3.4-3 Authorization to Release Information

The Applicant or Member specifically authorizes the Medical Staff and Hospital and their authorized representatives to release such information to other hospitals, health care facilities, and their agents, who solicit such information for the purposes of evaluating the Applicant's or Member's professional qualifications pursuant to a request for appointment and/or Clinical Privileges.

3.5 Procedure for Appointment

3.5-1 Request for an Application

An Applicant expressing interest in joining the Medical Staff or in possessing Clinical Privileges shall contact the Medical Staff Services Department to request an application.

Applicants who do not meet minimum eligibility requirements required under Article II will not be sent an application packet.

3.5-2 Submission of Application

(a) The application for Medical Staff appointment shall be submitted by the Applicant to the Medical Staff Office. It must be accompanied by payment of such processing fees as shall be determined from time to time by the MEC. After reviewing an application to determine that all questions have been answered, and after reviewing all references and other information or materials deemed pertinent, and after verifying the information provided in the application with the primary sources, the Medical Staff Office shall transmit the application and all supporting materials to the appropriate Department Chairperson.

(b) An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information verified. An application shall become incomplete if the need arises for new, additional or clarifying information anytime during the evaluation process. Any application that continues to be incomplete forty-five (45) days after the Applicant has been notified of the additional information required shall be deemed to be withdrawn. It is the responsibility of each Applicant to provide a complete application, including adequate responses from references. Incomplete applications will not be processed.

3.5-3 Physician Relations Committee Procedure

(a) The Physician Relations Committee shall examine the application and evidence of the Applicant's character, professional competence, qualifications, prior behavior and ethical standing and shall determine, through information contained in references

(b) As part of the process in making a recommendation, the Physician Relations Committee may require the Applicant to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Physician Relations Committee. The results of any such examination shall be made available to the Physician Relations Committee for its consideration. Failure of an Applicant to undergo such an examination within a time frame as determined by the Physician Relations Committee after being requested to do so in writing by the Physician Relations Committee, shall constitute a voluntary withdrawal of the application for appointment or reappointment and Clinical Privileges, and all processing of the application shall cease.

(c) The Physician Relations Committee shall have the right to require the Applicant to meet with the committee to discuss any aspect of the Applicant's application, qualifications or Clinical Privileges requested.

(d) The Physician Relations Committee may use the expertise of the Department Chairperson or any member of the Department or an outside consultant, if additional information is required regarding the Applicant's qualifications.

(e) If the Physician Relations Committee's recommendation for appointment is favorable following review and consideration of the applicable Chairperson's report and other relevant information, the Committee shall forward its favorable recommendation to the MEC. All recommendations for appointment must specifically recommend the Clinical Privileges to be granted, which may be qualified by probationary or other conditions or restrictions as deemed appropriate by the Committee.

(f) If the Physician Relations Committee's recommendation for appointment is unfavorable following review and consideration of the applicable Chairperson's report, the Committee shall forward its unfavorable recommendation to the MEC. All unfavorable recommendations must state the specific reasons for the unfavorable recommendation.

(g) No later than sixty(60) days from receipt of a completed application, the Physician Relations Committee shall send its recommendation, all supporting documentation and a copy of the completed application to the MEC.

(h) The Chairperson of the Physician Relations Committee shall be available to the MEC and to the Board to answer any questions that may be raised with respect to the Physician Relations Committee's recommendation.

3.5-4 MEC Procedure

(a) No later than sixty (60) days after receipt of the written findings and recommendation of the Physician Relations Committee, the MEC shall:

1) adopt the findings and recommendation of the Physician Relations Committee;

2) refer the matter back to the Physician Relations Committee for further consideration and preparation of responses to specific questions raised by the MEC prior to its final recommendation; or

3) set forth in its report and recommendation the reasons, along with supporting information and documentation, for its modification of the Physician Relations Committee's recommendation. Thereafter, the MEC's recommendation shall be forwarded, together with the Physician Relations Committee's findings and recommendation, through the CEO to the Board.

(b) If the recommendation of the MEC entitles the Applicant to request a hearing pursuant to the Corrective Action and Fair Hearing Plan, the recommendation shall be forwarded to the CEO who will promptly notify the Applicant of such recommendation by Special Notice as more fully described in the Corrective Action and Fair Hearing Plan. The CEO shall then hold the application until after the Applicant has exercised or waived the right to a hearing, after which the CEO shall forward the recommendation of the MEC, together with the completed application and all supporting documentation to the Board for consideration and further action.

3.5-5 Board Procedure

Unless a fair hearing is requested, the Board shall approve or deny the application not later than sixty (60) days after receiving the MEC's recommendation and in no event later than one-hundred (120) days after receiving the Physician Relations Committee recommendation. During such time, the Board may request further review or input as it deems appropriate before acting upon the application, as necessary. The Board may appoint a subcommittee comprised of the Chairman of the Board or designee and two (2) voting Board members ("Board Subcommittee") to render a decision on behalf of the full Board if the next
regularly scheduled Board meeting would not be held within the time frame specified above.

ARTICLE IV

REAPPOINTMENT

4.1 Procedure for Reappointment

Unless otherwise specified, all terms, conditions and procedures relating to initial appointment shall apply to reappointment.

4.1-1 Application

(a) Each Member who is eligible for reappointment to the Medical Staff shall be responsible for completing a reappointment application form. The completed reappointment application must be submitted to the Medical Staff Service Department within thirty (30) days of receipt of the application. If a Member does not submit his or her reappointment application within this

thirty (30) day time period, the Member applying for reappointment will receive a notice informing him or her to submit a completed application within thirty (30) days.

(b) Reappointment, if granted by the Board, shall be for a period of not more than two (2) years with reappointments staggered in a manner as determined by the Medical Staff Office with approval by the Board. If an application for reappointment is submitted and the Board has not acted on the application prior to the expiration of the Member's current term of appointment, the Member's current term shall continue in effect until such time as the Board acts on the reappointment application.

4.1-2 Factors to be Considered

(a) Each recommendation concerning reappointment of a Member on the Medical Staff shall be based upon such Member's:

1) patient contacts at the Hospital during the previous appointment term for purposes of determined competency;

2) ethical behavior, clinical competence and clinical judgment in the treatment of patients;

3) compliance with the Hospital Bylaws, Medical Staff Bylaws and Related Manuals, and relevant policies;

4) behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of this Hospital, and general attitude toward patients, the Hospital, and its personnel;

5) use of the Hospital's facilities for patients, taking into consideration the individual's comparative utilization patterns;

6) current physical, mental, and emotional health status;

7) capacity to satisfactorily treat patients as indicated by the results of the Hospital's performance improvement activities or other ongoing professional practice evaluation and reasonable indicators of continuing competency;

8) satisfactory completion of fifty (50) Level I Continuing Medical Education hours every two (2) years or maintenance of certification by the accrediting specialty board

9) current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments, and settlements;

10) current licensure, including currently pending challenges to any license or registration;

11) voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction or loss of Clinical Privileges at another Hospital or other health care facility;

12) relevant findings from the Hospital's performance improvement activities; and

13) other reasonable indicators of continuing qualification.

(b) To be eligible to apply for renewal of Clinical Privileges, a Member must have performed sufficient procedures, treatments or therapies in the previous appointment term to enable the Department Chairperson to assess the Applicant's clinical competence.

(c) A Member with low volume or no patient care activity at the Hospital will be requested to provide evidence of clinical competency by submitting documentation of activity at a primary facility where the Applicant holds clinical privileges and a current delineation of clinical privileges form approved by the primary facility along with an attestation statement from the facility to confirm the Clinical Privileges being requested.

4.2 Physician Relations Committee Procedure

4.3-1 <u>Physician Relations Committee Procedure</u>

The Physician Relations Committee shall follow the process described in Section 3.5-4 of this Credentialing Manual.

4.3 MEC Procedure

4.4-1 <u>MEC Procedure</u>

The MEC shall follow the process described in Section 3.5-5 of this Credentialing Manual.

4.4 Board Procedure

4.5-1 <u>Board Procedure</u>
The Board shall follow the process described in Section 3.5-6 of this Credentialing Manual.

ARTICLE V

CLINICAL PRIVILEGES

5.1 Exercise of Clinical Privileges for Physicians, Dentists, and Podiatrists

5.1-1 Membership on the Medical Staff does not confer or automatically grant Clinical Privileges or the right to practice medicine at the Hospital.

5.1-2 Each Member of the Medical Staff shall be entitled to exercise only those Clinical Privileges specifically granted by the Board.

5.1-3 The granting of Clinical Privileges shall carry with it acceptance of the obligations of such Clinical Privileges, including emergency service and other rotational or coverage obligations established by the Board, Hospital Administration or Medical Staff leadership to fulfill the Hospital's responsibilities under the Emergency Medical Treatment and Labor Act and/or other applicable requirements or standards.

5.1-4 The Clinical Privileges recommended to the Board shall be based upon consideration of the following:

(a) the Applicant's education, training, experience, background, demonstrated current competence and judgment, professional conduct, references, utilization patterns, and health status;

(b) the Applicant's ability to meet all current criteria for the requested Clinical Privileges;

(c) availability of qualified physicians or other appropriate Members to provide medical coverage for the Applicant in case of the Applicant's illness or unavailability;

(d) adequate levels of professional liability insurance coverage (participation in the Indiana Patient Compensation Fund) with respect to the Clinical Privileges requested;

(e) the Hospital's available resources and personnel;

(f) any previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration;

(g) any information concerning professional review actions, voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary relinquishment limitation, reduction or loss of Clinical Privileges at another Hospital or health care facility; and

(h) other relevant information, including a written report and findings by the Chairperson of each Department in which such Clinical Privileges are sought and the findings of any focused professional practice evaluation.

5.1-5 The Applicant shall have the burden of establishing qualifications for and competence to exercise the Clinical Privileges requested.

5.2 Clinical Privileges for Oral Surgeons/Dentists

5.2-1 The scope and extent of Clinical Privileges that an oral surgeon or Dentist may be granted in the Hospital shall be delineated and recommended in the same manner as other Clinical Privileges.

5.2-2 Oral surgeons and Dentists shall be under the overall supervision of the Chairperson of the Department of Surgery. A designated Physician shall be responsible for the medical care of the patient throughout the period of Hospitalization.

5.2-3 "Oral surgeons" refers to licensed dentists who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the American Board of Oral and Maxillofacial Surgery.

5.2-4 Oral surgeons or Dentists shall be responsible for the dental care of the patient, including the dental history and physical examination as well as all appropriate elements of the patient's record. Oral surgeons and Dentists may write orders within the scope of their license and consistent with their Clinical Privileges and applicable Medical Staff policies

5.3 Voluntary Relinquishment of Privileges

5.3-1 Request to Relinquish Clinical Privileges

(a) A Member who desires to voluntarily relinquish any one (1) or more of the Clinical Privileges granted to him or her may submit a written request to the President of the Medical Staff specifying the Clinical Privilege(s) that he or she would like to relinquish. This request for relinquishment of Clinical Privileges will not be effective until acknowledged in writing by the Board.

(b) The procedure set forth shall not apply to situations where the Member has been deemed by the Hospital to have voluntarily relinquished Clinical Privileges pursuant to this Credentialing Manual, the Bylaws, Corrective Action and Fair Hearing Plan, or the Hospital Bylaws or policies.

(c) Likewise, voluntary relinquishment of Clinical Privileges while under an investigation or in return for not conducting an investigation will be considered a "surrender" of such Clinical Privileges, and will be reported as required by applicable Federal law.

5.3-2 Procedure for Relinquishment of Clinical Privileges

(a) Upon the receipt of a request to relinquish one (1) or more Clinical Privileges, the President of the Medical Staff and/or the MEC shall review the request and forward a recommendation to the Board for final action. The President of the Medical Staff and/or the MEC may request a meeting with the Member involved if the decrease of the Clinical Privileges would create a deficiency in available Hospital services. A report of such meeting shall be submitted to the Board with the recommendation of the President of the Medical Staff and/or the MEC.

(b) The Board shall act on the request and its decision shall be reported in writing by the CEO to the Member, the MEC, the Physician Relations Committee and the Chairperson of the applicable Department. The decision of the Board may specify a specific date on which relinquishment of clinical privilege(s) shall become effective.

(c) Failure to request relinquishment of any Clinical Privileges pursuant to this Section 5.6 or to adhere to the effective date specified by the Board for the relinquishment of the Clinical Privileges in question shall constitute grounds for professional review action pursuant to the Corrective Action and Fair Hearing Plan.

5.4 Temporary Clinical Privileges

5.4-1 Temporary Clinical Privileges

(a) Temporary Clinical Privileges are not routinely granted to Applicants. Temporary Clinical Privileges may be granted to Physicians, Dentists, Podiatrists, and AHPs by the CEO in the following four (4) circumstances:

- to fulfill an important patient care need;
- when an Applicant, including AHP Applicants, with a complete application for Membership and/or Clinical Privileges is awaiting review and approval by the MEC and the Board;
- to address locum tenens needs; or
- organ, tissue, and eye recovery

5.4-2 Important Patient Care Need

Whenever a patient is in need of the particular skills or experience of a particular Physician, Dentist, Podiatrist, or AHP, Temporary Clinical Privileges may be granted for a limited period of time, not to exceed one hundred twenty (120) days on a case by case basis upon the recommendation of the relevant Department Chairperson and approval of the CEO. Prior to review and recommendation, the Applicant must:

1) Submit a complete application, including a specific statement of the reason for requesting Temporary Clinical Privileges;

2) Have no pending or previous denial, restriction, or limitation to Indiana licensure or certification;

3) Have not been subject to involuntary termination of medical staff, membership at another health care organization; and

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

The following information must be verified prior to the granting of Temporary Clinical Privileges:

1) Current unlimited professional licensure;

2) Relevant training and experience;

3) Current professional liability/malpractice insurance coverage and qualified health care provider status under the Indiana Medical malpractice Act;

4) Current, unrestricted DEA/CSR registration;

5) Ability to perform Clinical Privileges requested;

6) Results of the National Practitioner Data Bank query have been obtained and evaluated; and

7) At minimum, one reference from a previous hospital, department chairperson.

5.4-3 Applicants awaiting review by the MEC

For Applicants awaiting review and approval of Membership and Clinical Privileges only by the MEC or Board, Temporary Clinical Privileges may be granted only after the Applicant's application has been deemed complete and the Physician Relations Committee has rendered a favorable recommendation to the MEC.

5.4-4 Locum Tenens

Temporary Clinical Privileges may be granted to Applicants seeking to provide patient care on a locum tenens basis, not to exceed sixty (60) days upon the recommendation of the relevant Department Chairperson and the CEO. Prior to review and recommendation, the Applicant must:

1) Submit a complete application, including a specific statement of the reason for requesting Temporary Clinical Privileges;

2) Have no pending or previous denial, restriction, or limitation to Indiana licensure or certification;

3) Have not been subject to involuntary termination of medical staff, membership at another health care organization; and

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

The following information must be verified prior to the granting of Temporary Clinical Privileges:

1) Current unlimited professional licensure;

2) Relevant training and experience;

3) Current professional liability/malpractice insurance coverage and qualified health care provider status under the Indiana Medical Malpractice Act;

4) Current, unrestricted DEA/CSR registration, if applicable;

5) Ability to perform Clinical Privileges requested;

6) Results of the National Practitioner Data Bank query have been obtained and evaluated; and

7) At minimum, one reference from a previous hospital, department chairperson.

5.4-5 Special Requirements

Special requirements of supervision and reporting may be imposed by the Department Chairperson concerned on any individual granted Temporary Clinical Privileges. Temporary Clinical Privileges shall be immediately terminated by the CEO or a designee upon notice of any failure by the individual to comply with such special conditions.

5.4-6 Termination of Temporary Clinical Privileges

(a) The CEO may, at any time after consulting with the President of the Medical Staff, the Physician Relations Committee Chairperson or the Chairperson of the Department responsible for the individual's supervision, terminate temporary admitting privileges. Clinical Privileges shall then be terminated when the individual's inpatients 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 granted Temporary Clinical Privileges, a termination of temporary Clinical Privileges may be imposed by the CEO, the CMO, the Department Chairperson or the President of the Medical Staff, and such termination shall be immediately effective.

(b) The appropriate Department Chairperson, the CMO or the President of the Medical Staff shall assign to a Member the responsibility for care of such terminated individual's patients until discharged from the Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.

(c) The granting of any temporary Clinical Privileges is a courtesy on the part of the Hospital and any or all may be terminated if a clinical question or concern has been raised. Neither the granting, denial nor termination of such Clinical Privileges shall entitle the individual concerned to any of the procedural rights provided in the Corrective Action and Fair Hearing Plan.

(d) Temporary Clinical Privileges shall be automatically terminated at such time as the MEC recommends not to appoint the Applicant to the Medical Staff or otherwise recommends a denial of requested Clinical Privileges.Similarly, Temporary Clinical Privileges shall be automatically modified to conform to the recommendation of the MEC that the Applicant be granted Clinical Privileges different from those Temporary Clinical Privileges granted by the CEO and Department Chairperson.

5.5 Emergency Clinical Privileges

5.5-1 Scope.

(a) In a declared emergency, any duly licensed or certified practitioner may be granted certain Emergency Clinical Privileges by the CEO to the extent permitted by his or her license or certification.

(b) When the emergency situation no longer exists, patients will be assigned by the President of the Medical Staff to Members with appropriate Clinical Privileges. The wishes of a patient will be considered in the selection of a substitute Physician.

(c) Emergency Clinical Privileges may be exercised at any Hospital facility or any temporary facility for which the Hospital has staffing responsibility under the CEMP.

5.5-2 Declared Emergency.

Emergency Clinical Privileges may be granted in the event of a declared emergency under the Indianapolis Comprehensive Emergency Management Plan (CEMP) or as otherwise determined by the CEO. Upon the declaration of such an emergency, the CEO or designee may grant Emergency Clinical Privileges to any Physician, Dentist, or AHP who is a member in good standing of the medical staff or has clinical privileges at any hospital that is a participant in the CEMP Health and Medical Emergency Support Function (a participating hospital) or at any other hospital or health care facility determined to be acceptable by the CEO or designee.

(a) An emergency is defined as the condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm or danger.

5.5-3 Procedure.

(a) In order to be granted Emergency Privileges, individuals must present (1) a current professional license to practice in the State of Indiana, and (2) a Hospital photo identification or other photo identification in the event the practitioner's home Hospital does not issue photo identifications. Practitioners with Emergency Privileges shall use reasonable judgment in determining the type of patient care to provide during the emergency, but may provide any type of care necessary as a life-saving measure or to prevent serious harm, as long as the care provided is within the scope of the individual's licensure and practice.

(b) To the extent permitted under the circumstances of the emergency, the Medical Staff Service Department will attempt to verify the credentials of any individual granted Emergency Privileges by contacting the individual's hospital of record. Emergency Privileges shall terminate immediately when the emergency is declared over by an authorized public official. Emergency Privileges may also be immediately terminated, with or without cause, by the CEO, President of the Medical Staff or CMO or designee of any of the above. Notwithstanding any other provision of the Hospital Bylaws and Medical Staff Bylaws, any such termination shall not give rise to the hearing or appeal rights set forth in the Corrective Action and Fair Hearing Plan.

5.6 Procedure for Requesting Additional Clinical Privileges

5.6-1 Application for Additional Clinical Privileges

Whenever, during the term of Membership, additional Clinical Privileges are desired, the Member requesting additional Clinical Privileges shall apply in writing to the Physician Relations

Committee Chairperson. The Member shall state in detail the specific additional Clinical Privileges desired and the individual's relevant recent training and experience which justify the additional privileges. This application shall be transmitted by the Physician Relations Committee Chairperson to the appropriate Department Chairperson. Thereafter, it shall be processed in the same manner as an application for initial Clinical Privileges as set forth in Section 3.5 herein.

5.6-2 <u>Factors to be Considered</u>

(a) In sole discretion of both the Physician Relations Committee and MEC, recommendations for additional Clinical Privileges may be based upon:

- relevant recent training;
- observation of patient care provided;
- review of the records of patients treated in the Hospital or at other health care facilities;
- findings or results of the Hospital's Quality Assurance and/or Performance Improvement activities;
- Applicant's ability to meet the qualifications and criteria for the Clinical Privileges requested;
- other reasonable indicators of the individual's continuing qualifications for the privileges in question; and
- the statements from relevant specialty societies.

(b) The recommendation for additional Clinical Privileges may carry with it such requirements for supervision or consultation, or other conditions, for such periods of time as are thought necessary.

5.7 Responsibility for Maintenance of Credential File

5.7-1 <u>Current Copies of All Documents</u>

All Members and AHPs are responsible for providing current copies of supporting documents to their respective credentials file. These documents include an Indiana license to practice medicine or practice allied health as appropriate, Indiana CSR, federal DEA, proof of status as a qualified health care provider under the Indiana Medical Malpractice Act, and satisfaction of Continuing Medical Education requirements if requested.

5.7-2 <u>Automatic Suspension of Clinical Privileges</u>

Failure to provide current information by the expiration or within (forty-five (45) days past its due date, as applicable, will result in automatic suspension of Clinical Privileges pending the next MEC meeting. Reinstatement will be automatic once the information is

supplied and deemed adequate by the MEC. Should the Member fail to provide the information during the suspension and a time period of three (3) months has elapsed, the matter will be referred to the MEC by the Physician Relations Committee with a recommendation that this failure to supply information is considered a voluntary resignation from the Medical Staff.

ARTICLE VI

PRIVILEGES FOR NEW PROCEDURES AND NEW TECHNOLOGY

6.1 Requests for Clinical Privileges for New Procedures and New Technology

For all requests for Clinical Privileges to perform procedures, utilizing a new device or a new approach for which there are no approved criteria at the Hospital, the Board must determine, following recommendation of the Physician Relations Committee whether it will grant the Clinical Privilege. The Board will use the following procedure to develop criteria for its consideration whether to grant such requests. Requests for which the Board has approved no specific criteria within a reasonable period of time will be processed using the general criteria of adequate education, training, clinical experience, and references demonstrating current clinical competence.

6.1-1 Procedure for Developing Privilege Criteria

Whenever a request for Clinical Privileges arises for which there is no policy or current review criteria, the Physician Relations Committee will follow these steps to coordinate the development of a policy and applicable criteria:

(a) If the issue pertains to the use of new technology, a new treatment protocol, a new device or new approach, the burden is initially on the requesting Physician to provide information about the device, technology or protocol. The requesting Member must provide a comprehensive briefing concerning the new technique or procedure. This briefing should include information concerning the development of the new technology, the name of other hospitals in which it is used, any evidence based medicine demonstrating the risks and benefits of this technology, any product literature or education syllabus addressing the technology and the names of any residency training directors responsible for providing training in this area. Information regarding cost/benefit and reimbursement data must be provided by the requesting Member if available. Use of a non FDA approved device or off label uses should receive IRB review and recommendation.

(b) The Physician Relations Committee will review the request and will determine if the procedure or equipment should be permitted within the Hospital. When making this recommendation, the Physician Relations Committee should discuss the Hospital's current plan of care, whether or not the new technology/procedure is of proven clinical efficacy and effectiveness, if the new procedure/technology carries a greater risk than existing conventional therapy. Analysis of the financial impact to the Hospital must also be considered.

(c) The Physician Relations Committee will request each Department/subspecialty or multi- specialty task force to provide it with advice concerning any clinical issues associated with the request.

(d) The task force shall complete its review within a reasonable period of time and provide a recommendation to the Physician Relations Committee concerning the specific issue:

1) The type of basic education and, if necessary, continuing education required to exercise the privileges safely and effectively; and

2) The number of years of formal training, and in what field(s) (and, if applicable, continuing training-either didactic or hands-on).

6.1-2 The recommendations of the specialty(ties)/task force will be reviewed by the Physician Relations Committee. If there is general agreement concerning the proposed privileging criteria the Physician Relations Committee will determine if the criteria are acceptable. If the advising committees have been unable to agree on the amount of education, training or experience necessary, the Physician Relations Committee will draft proposed criteria. Such criteria will be submitted to the involved specialty(ies) with a request that each group review and comment on the proposed rule.

6.1-3 The proposed criteria will then be submitted to the MEC for final review and recommendation to the Board.

ARTICLE VII

PROCEDURE FOR LEAVE OF ABSENCE

7.1 Requests for Leave of Absence

Members may request a leave of absence by submitting a written request to the Medical Staff Office and CMO. The request must state the beginning and ending dates of the leave, which shall not exceed one (1) year, and the reasons for the leave, such as military duty, additional training, family matters or personal health condition. Absence from the Medical Staff and patient care responsibilities for longer than sixty (60) days shall require a Member to request a leave of absence. (*Exception of the sixty (60) day time frame would apply to those physicians on maternity leave up to twelve (12 weeks).

7.2 Procedure for Review of Requests for Leave of Absence

The Board delegates to the CEO the authority to make determinations in connection with requests for leaves of absence, provided that the Board reserves the right to make final determinations, in its discretion. In determining whether to grant a request, the CEO shall consult with the CMO and Chief of Staff, applicable Department Chairperson and the Physician Relations Committee Chairperson and use his or her best efforts to make a determination within thirty (30) days of the receipt of the written request and of any clarifying information the CEO may request.

7.3 Requests for Reinstatement

No later than thirty (30) days prior to the conclusion of the leave of absence, the Member may request reinstatement by providing the CEO a written summary of professional activities during the leave of absence. The CEO shall refer the matter to the Physician Relations Committee and MEC for a recommendation. The individual bears the burden of providing information and documentation sufficient to demonstrate current competence and all other applicable qualifications. The individual shall provide any information requested by the CEO, the Physician Relations Committee or the MEC, including the execution of any releases that may be necessary to cause and permit third parties, including the Member's physician, to respond to any requests by CEO or Medical Staff for additional information or clarification.

7.3-1 Report of Individual's Physician

If the leave of absence was for health reasons, the request of reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a Hospital practice and safely executing the Clinical Privileges requested. A return to work evaluation/reinstatement exam will be completed by HRH Associate Health.

7.3-2 Approval by the CEO

The CEO, after considering the recommendations of the Physician Relations Committee and MEC, may approve reinstatement to either the same or a different Staff category and may limit or modify the Clinical Privileges to be extended to the individual upon reinstatement or impose conditions for the individual's practice deemed reasonably necessary for patient safety or the effective operation of the Hospital.

7.3-3 FPPE

Members granted reinstatement after a leave of absence may, in the discretion of the Physician Relations Committee, the MEC or the CMO, be subject to a period of FPPE to confirm their readiness to resume practice. The terms of such FPPE be as deemed appropriate by the PRC, MEC or CMO under the facts and circumstance presented by the Member, the basis for their leave and available Hospital resources. A Members return to exercise of their privileges shall be conditional on successful completion of such review, in the sole discretion of the PRC, MEC or CMO. The terms of any such FPPE shall be communicated in writing.

7.4 Absence for Longer than One (1) Year

Absence for longer than one (1) year shall result in automatic relinquishment of Medical Staff appointment and Clinical Privileges unless an extension is requested in writing at least thirty (30) days prior to the end of the leave and granted by the Board. Extensions will be considered only in extraordinary cases of hardship and when extension of a leave is found to be in the best interest of the Hospital. Under no circumstances will a leave of absence exceed any single term of appointment to the Medical Staff.

7.5 No Entitlement to Leaves of Absence or Reinstatement

Leaves of absence and reinstatement are matters of courtesy, not of right. In the event that it is determined that a Member has not demonstrated good cause for a leave of absence or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal (except for those limited circumstances outlined in Section 7.3-2).

ARTICLE VIII

TELEMEDICINE

8.1 Credentialing and Privileging in Telemedicine

8.1 Telemedicine Privileges

(a) If the Hospital has a pressing clinical need for telemedicine services and an outside Physician can supply such services via a telemedicine link, the Hospital may

evaluate the use of temporary privileges for an outside Physician as addressed in Section 8.l(c) below. In such cases, the outside Physician must be credentialed and privileged to provide telemedicine services in accordance with Hospital standards and procedures applicable to the approved telemedicine services. The Medical Staff recommends those clinical services that may be appropriately delivered through telemedicine services and such services must be consistent with commonly accepted quality standards.

(b) Notwithstanding this Section 8.1, the Hospital shall comply with all Indiana and other applicable State laws and regulations to ensure that all telemedicine practice is authorized under existing law.

(c) Clinical Privileges may be granted for providing telemedicine services as described in this Section. The period of time shall be for a duration determined by the Medical Staff and not to exceed two (2) years, unless otherwise renewed. In order to reliably assess the quality and performance of a Physician's telemedicine practice, a Physician who has been granted clinical privileges to provide Telemedicine services must provide such telemedicine services at a sufficient volume and repetition to maintain such Clinical Privileges. If a Physician who has been granted Clinical Privileges to provide telemedicine services at the Hospital fails to utilize such Clinical Privileges or otherwise provide telemedicine services to Hospital patients at a satisfactory volume as determined by the Medical Staff, such Clinical Privileges shall cease and expire either six (6) months following the date Physician last provided telemedicine services at the Hospital or when otherwise notified by the Medical Staff.

(d) Members with Clinical Privileges who provide health care services to patients at or for other health care facilities through a telemedicine link should be credentialed and privileged according to the standards of the patient's facility and not this Hospital.

ARTICLE IX

EDUCATIONAL STAFF

9.1 Educational Staff

9.1-1 Qualifications/Application Process

(a) Educational Staff shall consist of Physicians and Dentists participating in post-graduate training such as fellowships, residency rotations or training programs and who are sponsored by a Member of the Active or Affiliate Staff . Educational Staff are not Members of the Medical Staff and their status as a member of the Education Staff expires at the end of the training or upon the resignation, suspension or disassociation from the Medical Staff of the sponsoring Member. Educational Staff status is offered as a courtesy to individuals participating in training and his or her Medical Staff sponsor. Requested permission to furnish medical care or other patient care services to patients at the Hospital and to utilize Hospital resources necessary to provide such services must be within the scope of current Clinical Privileges of the sponsoring Member. The sponsoring Member is required to oversee the educational staff member.

(b) An application for Training must be completed by all practitioners participating in a residency or fellowship training program sponsored by a Member of the Hospital's Medical Staff. This application will include copies of all medical licenses and registrations, evidence of professional liability coverage, Hospital photo ID or photo and a letter from the program director verifying that the Applicant is a participant of the residency program in good standing.

(c) A completed application and all accompanying documentation listed above must be submitted no fewer than thirty (30) days prior to commencement of the applicable residency or training program. Failure to receive the above items within the requested timeframe will result in the scheduled rotation being postponed or cancelled.

ARTICLE X

ALLIED HEALTH PROFESSIONALS

Allied Health Professionals are those licensed or certified individuals who the Board has determined are eligible to apply for Clinical Privileges consistent with the minimum eligibility and qualification requirements established by the Board, which will include their recognized scope of practice, licensure, certification, education, and demonstrated competency. Only those AHPs who have been granted Clinical Privileges consistent with their scope of practice may practice their medical specialty within the Healthcare System.
All AHPs who are eligible and granted Clinical Privileges will be classified into two (2) categories: Independent or Dependent. Clinical Privileges may be granted to AHPs for a period of time not to exceed two (2) years, unless otherwise renewed as provided for herein.

Allied Health Professionals are not Members of the Medical Staff, and as such, have no prerogatives or responsibilities of Medical Staff Membership.

10.1 Categories of Allied Health Professionals

10.1-1 Independent AHPs

"Independent AHPs" are those individuals who exercise independent medical judgment within the scope of his/her license or certificate. Independent AHPs may or may not be employed by a Member or the Hospital.

Independent Allied Health Nursing staff members shall have their credentials/privileges reviewed by the Vice President of Nursing who will assist the Medical Staff in the credentialing process. The Vice President of Nursing shall also collaborate with the Organized Medical Staff in formulation of policies and procedures affecting Independent Allied Health Nursing staff. The Vice President of Nursing will also be responsible for including Independent Allied Health Nursing Staff in decision-making regarding nursing care and providing educational activities including updates and policy changes that affect nursing clinical practice in the hospital environment.

10.1-2 Dependent AHPs

"Dependent AHPs" are those individuals who do not exercise independent medical judgment within the scope of his/her license or certificate. Dependent AHPs are employed by or directly supervised by a Member or the Hospital.

10.2 Eligibility

10.2-1 General Qualifications of AHP Applicants

All AHPs who apply for Clinical Privileges at the Hospital, either as an Independent or Dependent AHP, shall:

(a) be currently licensed or certified to practice his or her profession, as applicable;

(b) maintain a current collaborative or supervision agreement with a Member, as applicable;

(c) be located in sufficient proximity to the Hospital to provide timely and continuous care for patients in the Hospital;

(d) be covered by current, valid professional liability insurance coverage in such form and amounts satisfactory to the Hospital;

(e) be able to demonstrate to the satisfaction of the Board, Hospital, and Medical Staff, his/her:

1) background, education, relevant training, experience, and current demonstrated clinical competence:

2) adherence to the ethics of his or her profession;

3) good character and reputation;

4) ability to perform the clinical functions and activities requested;

5) ability to work harmoniously with others sufficiently to convince the Hospital that all patients treated by the individual will receive quality care and the Hospital will be able to operate in an orderly manner;

6) immunity to Rubella; and

7) current PPD/TB test records/Flu vaccination

10.2-2 Additional Requirements/Restrictions for AHPs

(a) Supervision by Employing or Supervising Member

1) Dependent AHPs may exercise Clinical Privileges only under the direct supervision of their employing or supervising Member. Except as permitted by law or Board-approved policy, "direct supervision" shall not require the actual physical presence of the employing or supervising Member.

2) Dependent AHPs may only exercise Clinical Privileges on the condition that they remain employees of or are directly supervised by a Member of the Medical Staff.

(b) <u>Revocation or Termination of Supervising Member's Membership/Clinical</u> Privileges

1) If the Membership or Clinical Privileges of the employing or supervising Member is revoked or terminated, for any reason, the Dependent AHP's Clinical Privileges shall be given 30 days to finalize an updated collaborative agreement with a member of the medical staff; if not completed within 30 days the AHP will be automatically deemed a voluntary resignation from the staff.

(c) Responsibilities of Employing or Supervising Member

1) The number of Dependent AHPs acting as employees of or under the supervision of one (1) Member, as well as the acts the AHP(s) may undertake, shall be consistent with applicable Indiana law, the Rules and Regulations of the Medical Staff or applicable policies of the Board.

2) It shall be the responsibility of the Hospital or Member employing the AHP to provide or to arrange for professional liability insurance in amounts required by the Board that covers any activities of the Dependent AHP at the Hospital and to furnish evidence of such coverage to the Hospital. The Dependent AHP shall exercise Clinical Privileges only while such coverage is in effect.

10.2-3 <u>Assumption of Duties and Responsibilities</u>

All AHPs shall assume such reasonable duties and responsibilities as the Physician Relations Committee, MEC or the Board shall require, including:

(a) provide appropriate continuous and timely care and supervision to all patients in the Hospital for whom the individual has responsibility;

(b) abide by all applicable provisions of the Hospital Bylaws, Medical Staff Bylaws and Related Manuals as shall be in force during the time the individual is granted permission to practice in the Hospital;

(c) accept Medical Staff committee or Department assignments and such other reasonable duties and responsibilities as shall be assigned;

(d) provide to the Hospital, with or without request, and, as it occurs, new or updated information that is pertinent to any question on the application form;

(e) appear for personal interviews as requested in regard to the application;

(f) refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(g) refrain from assuming responsibility for diagnoses or care of Hospitalized patients for which he or she is not qualified or without adequate supervision;

(h) refrain from deceiving patients as to his or her status as an AHP;

(i) seek consultation whenever appropriate or necessary;

(j) promptly notify the CEO or a designee of any change in eligibility for payments by third-party payers or for participation in any government healthcare program, including any sanctions imposed or recommended by the federal 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;

(k) abide by generally recognized ethical principles applicable to the individual's profession;

(l) participate in performance improvement monitoring and evaluation activities of the Hospital;

(m) complete, in a timely manner, the medical and other required records for all patients as required by the Medical Staff Bylaws and Related Manuals and other applicable policies of the Hospital; and,

(n) participate in applicable continuing education programs.

10.2-4 Professional Conduct

(a) AHPs who are granted Clinical Privileges are expected to relate in a positive and professional manner to other health care professionals, and to cooperate and work collegially with the Medical Staff leadership and Hospital management and personnel.

(b) Professional conduct shall also include, but not be limited to, each AHP's obligation to present himself or herself at the Hospital physically and mentally capable of providing safe and competent care to patients.

10.3 Application for Clinical Privileges

10.3-1 No Entitlement to Medical Staff Appointment

(a) AHPs applying for Clinical Privileges shall not be eligible for appointment to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Membership on the Medical Staff.

10.3-3 AHPs Requesting Clinical Privileges

(a) An application for Clinical Privileges is sent only to those Independent and Dependent AHP types or classes who have been approved by the Board, who meet the general and specific qualifications set forth in this Credentialing Manual and applicable Federal and State law. A list of approved AHP types shall be maintained in the Medical Staff Service Department for review. Any AHP type not listed may be approved by the Board following a recommendation of the MEC.

(b) Any AHP who requests an application for Clinical Privileges at the Hospital will initially be sent a letter that:

1) outlines the general qualifications set forth in this Article and in such other policies that relate to each Applicant's area of practice;

2) explains the review process; and

3) outlines the scope of practice established by applicable Indiana law and/or the Clinical Privileges approved by the Board for such AHPs in the Hospital.

(c) An Applicant will also be sent an application form which requests sufficient evidence that the Applicant meets the general qualifications outlined in this Article and as required by applicable law relating to each Applicant's area of practice.

(d) A completed application form with copies of all required documents must be returned to the Medical Staff Service Department within thirty (30) days after the Applicant's receipt of the application form if the Applicant desires further consideration.

10.3-4 Information to be Submitted With Applications

(a) For consideration by the Physician Relations Committee, AHP applications require detailed information concerning the Applicant's professional qualifications. This information will include professional references; education; work, licensure, and

privileging history; medical malpractice and insurance history; health status, and such other information as deemed appropriate by the Medical Staff and/or Board.

(b) Any application that does not provide the information requested on the application form will not be considered or processed.

10.3-5 Burden of Providing Information

(a) The Applicant shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.

(b) The Applicant shall have the burden of proving that all the statements made and information given on the application are true and correct.

(c) Any misstatement, omission and/or representation on the application, whether intentional or not, shall constitute cause for immediate cessation of the processing of the application, and no further processing shall occur.

(d) In the event that Clinical Privileges have been granted prior to discovery of such misstatement, misrepresentation or omission, such discovery shall result in automatic relinquishment of all Clinical Privileges, functions and activities, and designation as a Dependent AHP or Independent AHP. In either situation, there will be no entitlement to any grievance, hearing or appeal action.

10.3-6 Release and Immunity

By applying for Clinical Privileges, Applicants expressly accept and agree to the following conditions (regardless of whether Clinical Privileges are granted):

(a) The Applicant specifically authorizes the Hospital and its authorized representatives to consult with any third party who may have information bearing on the Applicant's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter reasonably having a bearing on the Applicant's qualifications to practice as a Dependent AHP or Independent AHP.

1) This authorization includes the right to inspect or obtain any and all communications, reports, records, and documents from said third parties.

2) The Applicant also specifically authorizes said third parties to release said information to the Hospital and its authorized representatives upon request.

(b) To the fullest extent permitted by law, the Applicant releases from any and all liability, the Hospital, its Board, officers, employees, and agents authorized representatives, and any third parties with respect to any acts, communications or documents, recommendations or disclosures involving the Applicant.

10.3-7 Non-Discrimination Policy

No individual shall be denied Clinical Privileges at the Hospital on the basis of sex, race, creed, religion, color, national origin or on the basis of any criteria unrelated to professional qualifications or to the Hospital's purposes, needs and capabilities.

10.4 Credentialing Procedure

10.4-1 Processing of Applications

(a) Completed applications shall be submitted to the Medical Staff Office.

After reviewing the application for completion and after verifying all references and other information provided in the application with the primary sources, the Medical Staff Service Department shall transmit the completed application along with all supporting materials to the Physician Relations Committee.

(b) An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied and all information verified.

(c) An application shall become incomplete if the need arises for new, additional or clarifying information anytime during the evaluation.

1) Any application that continues to be incomplete forty-five (45) days after the Applicant has been notified of the additional information required shall be deemed to be withdrawn.

2) It is the responsibility of the Applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

10.4-2 <u>Review by the Physician Relations Committee</u>

(a) The Physician Relations Committee may use the expertise of any individual on the Medical Staff or the Hospital or an outside consultant, if additional information is required regarding the Applicant's qualifications.

(b) In evaluating the application, the Credentials Committee may also meet with the Applicant and, when applicable, the employing or supervising Member.

10.4-3 Review by MEC

(a) Following review by the Physician Relations Committee regarding the Applicant's qualifications for the Clinical Privileges being requested, the Physician Relations Committee shall make a written report to the MEC regarding the Applicant's qualifications for the Clinical Privileges being requested.

(b) The MEC may use the expertise of any individual on the Medical Staff or the Hospital or an outside consultant, if additional information is required regarding the Applicant's qualifications.

(c) In evaluating the application, the MEC may also meet with the Applicant and, when applicable, the employing or supervising Member.

(d) Favorable Recommendations

1) If the MEC's recommendation is favorable to the Applicant, this recommendation will be forwarded to the Board for review and consideration at is next regularly scheduled meeting.

(e) Unfavorable Recommendations

1) If the MEC's initial recommendation is unfavorable to the Applicant, the Applicant and, when applicable, the employing or supervising Member shall be given the opportunity upon written request to meet with the Physician Relations Committee before a final recommendation is made.

2) This meeting will be informal and shall not be considered a hearing for purposes of the Corrective Action and Fair Hearing Plan.

3) Following this meeting, the Physician Relations Committee shall make a recommendation to the MEC regarding the Applicant's request.

4) After receiving the Physician Relations Committee's recommendation, the MEC shall issue a final recommendation.

5) The MEC's final recommendation, whether favorable or unfavorable, will be forwarded to the Board for review and consideration at is next regularly scheduled meeting.

10.5 Re-Credentialing

The eligibility requirements, application requirements, and credentialing procedures outlined in Sections 10.2-10.4 for credentialing of AHPs will be applied to the renewal of AHP Clinical Privileges. Renewal, if granted by the Board, shall be for a renewal term of not more than two (2) years. During each AHP's renewal, the applicable Department Chairperson, Physician Relations Committee, and MEC shall review the utilization, performance improvement, and quality assurance data compiled during the AHP's prior term.

10.6 Corrective Action

10.6-1 No Entitlement to Medical Staffs Corrective Action and Fair Hearing Plan

AHPs shall not be entitled to the hearing and appeals procedures set forth in the Medical Staffs Corrective Action and Fair Hearing Plan or any other Hospital or Medical Staff policy or document.

10.6-2 Meeting following Denial or Revocation

(a) In the event that an AHP, excluding Hospital employees, is not granted Clinical Privileges at the Hospital or whose Clinical Privileges are revoked, the AHP, and when applicable, his or her employing or supervising Member, shall have the right to appear personally before the Physician Relations Committee to discuss the decision.

(b) If the AHP desires to appear before the Physician Relations Committee, he or she must make such request:

1) in writing; and

2) within ten (10) days of the decision to deny or revoke Clinical Privileges.

(c) Should the AHP request an appearance in a timely manner, the AHP will be informed of the general nature of the information supporting the decision to deny or revoke prior to the scheduled meeting.

(d) At the meeting, the AHP and, when applicable, his or her employing or supervising Member, shall be invited to discuss the decision.

(e) Following the meeting, the AHP will be notified in writing within ten (10) days of the Physician Relations Committee's final decision, whether favorable or unfavorable.

ARTICLE XI

AMENDMENT

11.1 Amendment of Credentialing Manual and Rules and Regulations

This Credentialing Manual and the Rules and Regulations may be amended or repealed, in whole or in part, by one of the following mechanisms:

15.1-1 A resolution of the MEC recommended to and adopted by the Board; or

15.1-2 A resolution of the Board, taken on its own initiative after notice to the Medical Staff of its intent, including a reasonable period of time for response.

11.2 Responsibilities and Authority

The MEC may act on behalf of the Medical Staff in formulating and making the necessary recommendations to the Board with regard to the amendment or repeal of all or any part of this Credentialing Manual or the Rules and Regulations

11.3 **Origination**

The MEC, Bylaws Committee or any Member of the Medical Staff may propose an amendment to this Credentialing Manual or the Rules and Regulations. All proposed amendments, if not originating in the MEC, must be presented to the MEC for review and recommendation, as appropriate. This Credentialing Manual and the Rules and Regulations shall be reviewed no less than every three (3) years by the MEC, or Bylaws Committee for compliance with applicable legal and accreditation requirements.

ARTICLE XII

ADOPTION

12.1 Medical Staff

This Credentialing Manual was recommended to the Board by the MEC and adopted by the Board in accordance with and subject to the Medical Staff Bylaws.

By:______________________________

Chief of Medical Staff

Date Approved:

12.2 Board

This Credentialing Manual was approved and adopted by consent of resolution of the Board after considering the MEC's recommendation and in accordance with and subject to the Hospital's Bylaws.

By:______________________________

Chairperson, Board of Trustees

Date Approved:

Approved by Medical Executive Committee: 04/10/2023

Approved by Board of Trustees: