MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF PIEDMONT NEWNAN HOSPITAL

POLICY ON ALLIED HEALTH PROFESSIONALS

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ARTICLE 1

DEFINITIONS

1.1 Definitions:

The following definitions apply to terms used in this Policy:

(1) "ALLIED HEALTH PROFESSIONALS" ("AHPs") means individuals other than Medical Staff members who are authorized by law and by the Hospital to provide patient care services within the Hospital.

(2) "BOARD" means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital.

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

(4) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services.

(5) "CREDENTIALS POLICY" means the Hospital's Medical Staff Policy on Appointment, Reappointment and Clinical Privileges.

(6) "DAYS" means calendar days.

(7) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(8) "HOSPITAL" means Piedmont Newnan Hospital.

(9) "MEDICAL EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff.

(10) "MEDICAL STAFF" means all physicians, dentists, oral surgeons, and podiatrists who have been appointed to the Medical Staff by the Board.

(11) "MEDICAL STAFF LEADER" means any Medical Staff officer, department chair, and committee chair.

(12) "MEMBER" means any physician, dentist, oral surgeon, and podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.

(13) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, Hospital mail, or hand delivery.

(14) "ORAL AND MAXILLOFACIAL SURGEON" means an individual with a D.D.S. or D.M.D. who has completed an accredited residency in oral and maxillofacial surgery and is fully licensed in the State of Georgia to practice oral and maxillofacial surgery in all its phases.

(15) "PATIENT CONTACTS" includes any admission, consultation, procedure, in person response to emergency call, evaluation, treatment, or service performed in any facility or venture operated by the Hospital or in which the Hospital has an ownership interest, including outpatient facilities.

(16) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(17) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

(18) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

(19) "SUPERVISING PHYSICIAN" means the physician who employs and/or supervises an Advanced Dependent Practitioner or Dependent Practitioner and who is fully responsible for the actions of that individual while he or she is practicing in the Hospital.

(20) "SUPERVISION" means the supervision of (or collaboration with) an Advanced Dependent Practitioner or a Dependent Practitioner by a Supervising Physician, that may or may not require the actual presence of the Supervising Physician, but that does require, at a minimum, that the Supervising Physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) shall be determined at the time each Advanced Dependent Practitioner or Dependent Practitioner is credentialed and shall be consistent with any applicable written supervision or collaboration agreement that may exist.

(21) "VICE PRESIDENT FOR MEDICAL AFFAIRS" (or "VPMA") means the individual appointed by the Board to act as the chief medical officer of the Hospital, in cooperation with the President of the Medical Staff.

1.2 Time Limits:

Time limits referred to in this Policy are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.3 Delegation of Functions:

When a function is to be carried out by a person or committee, the person, or the committee through its chair, may delegate performance of the function to one or more qualified designees.

ARTICLE 2

SCOPE AND OVERVIEW OF POLICY

2.1 Scope of Policy:

This Policy addresses those Allied Health Professionals who are permitted to provide services at the Hospital. It also addresses those physicians who do not desire Medical Staff appointment, but who nevertheless seek to exercise certain limited privileges at the Hospital under the conditions set forth in this Policy (e.g., House Physicians; moonlighting residents). This Policy sets forth the credentialing process and the general practice parameters for these individuals, as well as guidelines for determining the need for additional categories of Allied Health Professionals at the Hospital.

2.2 Categories of Allied Health Professionals:

Only those specific categories of Allied Health Professionals that have been approved by the Board of Directors shall be permitted to practice at the Hospital. All such categories shall be classified as either "Licensed Independent Practitioners," "Advanced Dependent Practitioners," or "Dependent Practitioners," each having a slightly different relationship to the Hospital.

2.3 Licensed Independent Practitioners:

(a) "Licensed Independent Practitioners" (hereinafter referred to as Category I practitioners) shall include all those Allied Health Professionals who are licensed or certified under state law, authorized to function independently in the Hospital, and granted clinical privileges. Category I practitioners shall also include that small class of physicians referenced above who seek to exercise certain limited clinical privileges at the Hospital under the conditions set forth in this Policy. These individuals require no formal or direct supervision by a physician.

(b) A current listing of the specific categories of Allied Health Professionals functioning in the Hospital as Category I practitioners is attached to this Policy as Appendix A. This Appendix may be modified or supplemented by action of the Board after receiving the recommendations of the Credentials and Medical Executive Committees, without the necessity of further amendment of this Policy.

2.4 Advanced Dependent Practitioners:

(a) "Advanced Dependent Practitioners" (hereinafter referred to as Category II practitioners) shall include all those Allied Health Professionals who are licensed or certified under state law, are granted clinical privileges, and function in the Hospital under the supervision of a physician(s) appointed to the Medical Staff.

The supervising physician(s) is responsible for the actions of the Category II practitioner in the Hospital.

(b) A current listing of the specific categories of Allied Health Professionals functioning in the Hospital as Category II practitioners is attached to this Policy as Appendix B. This Appendix may be modified or supplemented by action of the Board after receiving the recommendations of the Credentials Committee and Medical Executive Committee, without the necessity of further amendment of this Policy.

2.5 Dependent Practitioners:

(a) "Dependent Practitioners" (hereinafter referred to as Category III practitioners) shall include all those Allied Health Professionals who are permitted to practice in the Hospital only under the direct supervision of a physician(s) appointed to the Medical Staff and who function pursuant to a scope of practice. The supervising physician(s) is responsible for the actions of the Category III practitioner in the Hospital.

(b) A current listing of the specific categories of Allied Health Professionals functioning in the Hospital as Category III practitioners is attached to this Policy as Appendix B. This Appendix may be modified or supplemented by action of the Board, after receiving the recommendations of the Credentials and Medical Executive Committees, without the necessity of further amendment of this Policy.

2.6 Additional Policies:

The Board shall adopt a separate policy for each category of Allied Health Professional that it approves to practice in the Hospital. These separate policies shall supplement this Policy and shall address the specific matters set forth in Section 3.2 of this Policy.

ARTICLE 3

GUIDELINES FOR DETERMINING THE NEED FOR
NEW CATEGORIES OF ALLIED HEALTH PROFESSIONALS

3.1 Determination of Need:

Whenever an Allied Health Professional in a category that has not been approved by the Board requests permission to practice at the Hospital, the Chief Executive Officer shall appoint an ad hoc committee to evaluate the need for that particular category of Allied Health Professional and to make a recommendation to the Board. As part of the process, the Allied Health Professional shall be invited to submit information about the nature of the proposed practice, why Hospital access is sought, and the potential benefits to the community by having such services available at the Hospital. The ad hoc committee may consider the following factors when making a recommendation to the Board as to the need for the services of this category of Allied Health Professionals:

(a) the nature of the services that could be offered;

(b) any state license or regulation which outlines the scope of practice for the Allied Health Professional;

(c) any state "non-discrimination" or "any willing provider" laws that would apply to the Allied Health Professional;

(d) the patient care objectives of the Hospital, including patient convenience;

(e) how well the community's needs are currently being met and whether they could be better met if the services offered by the Allied Health Professional were provided by the Hospital or as part of its facilities;

(f) the type of training that is necessary to perform the services that could be offered and whether there are individuals with more training currently providing those services;

(g) the availability of supplies, equipment, and other necessary Hospital resources;

(h) the need for and availability of trained staff to support the services that would be offered; and

(i) the ability to appropriately supervise performance.

3.2 Development of Policy:

(a) If the ad hoc committee recommends that there is a need for the particular category of Allied Health Professional at the Hospital, the committee shall recommend:

(1) any specific qualifications and/or training that they must possess beyond that set forth in this Policy;

(2) a detailed description of their authorized clinical privileges;

(3) any specific conditions that apply to their functioning within the Hospital; and

(4) any supervision requirements, if applicable.

(b) In developing such recommendations, the ad hoc committee shall consult the appropriate department chair(s) and applicable state law and may contact applicable professional societies or associations. The ad hoc committee may also recommend to the Board the number of Allied Health Professionals that are needed in a particular category.

ARTICLE 4

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

4.1 General Qualifications:

To be eligible to apply for initial and continued permission to practice at the Hospital, an Allied Health Professional must:

(a) have a current, unrestricted license or certification to practice in Georgia and have never had a license or certification to practice revoked or suspended by any state licensing agency;

(b) where applicable to his or her practice, have a current, unrestricted DEA registration;

(c) have a primary office within Coweta County (if applicable), and reside close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital;

(d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;

(e) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid or other federal or state governmental health care program;

(f) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil penalties for the same;

(g) have never had clinical privileges or scope of practice denied, revoked, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(h) have never been convicted of, or entered a plea of guilty or no contest to, any felony, or any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;

(i) satisfy all additional eligibility qualifications relating to his or her specific area of practice that may be established by the Hospital;

(j) if seeking to practice as a Category II or Category III practitioner, have a supervision agreement with a physician who is appointed to the Medical Staff;

(k) be able to document his or her:

(1) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;

(2) adherence to the ethics of his/her profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and his/her profession;

(3) good reputation and character;

(4) ability to safely and competently perform the clinical privileges or scope of practice requested;

(5) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable him/her to maintain professional relationships with patients, families and other members of health care teams;

(6) recognition of the importance of, and willingness to support, the Hospital's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care; and

(l) hold and maintain certification in Advanced Cardiac Life Support through an American Heart Association-approved course. This requirement applies to all mid-level providers (PA, CRNA, PA AA, CNM, NP) who attend patients greater than fifteen (15) years of age.

4.2 Waiver of Criteria:

(a) Any individual who does not satisfy a criterion may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) The Board may grant waivers in exceptional cases after considering the findings of the Credentials and Medical Executive Committees or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

(c) No individual is entitled to a waiver or to a hearing if the Board determinates not to grant a waiver.

(d) A determination that an individual is not entitled to a waiver is not a "denial" of clinical privileges or scope of practice. Rather, that individual is ineligible to request clinical privileges or scope of practice.

4.3 No Entitlement to Medical Staff Appointment:

Allied Health Professionals shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.

4.4 Non-Discrimination Policy:

No individual shall be denied permission to practice at the Hospital on the basis of gender, race, creed, or national origin.

4.5 Assumption of Duties and Responsibilities:

As a condition of permission to practice at the Hospital, all Allied Health Professionals shall specifically agree to the following:

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

(b) to abide by all applicable bylaws, policies, rules and regulations of the Medical Staff and Hospital;

(c) to accept committee assignments, participation in performance improvement and peer review activities, and such other reasonable duties and responsibilities as may be assigned;

(d) to comply with clinical practice protocols and guidelines that are established by, and must be reported to, regulatory or accrediting agencies, or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance;

(e) to also comply with clinical practice protocols and guidelines pertinent to his or her specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or clearly document the clinical reasons for variance;

(f) to inform the VPMA of any change in the individual's status or any change in the information provided on the individual's application form. This information shall be provided with or without request, at the time the change occurs, and shall include, but not be limited to, changes in licensure status or professional liability insurance coverage, the filing of a lawsuit against the practitioner, changes in the individual's status at any other hospital, exclusion or preclusion from participation in Medicare or any sanctions imposed, and any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and

responsibilities of appointment because of health status issues, including impairment due to addiction, and any charge of, or arrest for, driving under the influence ("DUI");

(g) to immediately submit to a blood and/or urine test, or to a complete physical and/or mental evaluation, if at least two members of the Medical Executive Committee (or one member of the Medical Executive Committee and one member of the Administrative team) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Executive Committee member(s);

(h) to acknowledge that the individual has had an opportunity to read a copy of this Policy and any other applicable bylaws, policies, rules and regulations and agrees to be bound by them;

(i) to appear for personal interviews in regard to an application for permission to practice as may be requested;

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

(k) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate supervision;

(l) to refrain from deceiving patients as to the individual's status as an Allied Health Professional;

(m) to seek consultation when appropriate;

(n) to complete, in a timely manner, all medical and other required records, containing all information required by the Hospital;

(o) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;

(p) to satisfy applicable continuing education requirements;

(q) to promptly pay any applicable dues and assessments; and

(r) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if permission to practice has been granted prior to the discovery of a misstatement or omission, the permission may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to the procedural rights provided in this Policy.

4.6 Burden of Providing Information:

(a) Allied Health Professionals seeking permission to practice shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.

(b) Allied Health Professionals seeking appointment have the burden of providing evidence that all the statements made and information given on the application are accurate.

(c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

(d) It is the responsibility of the individual seeking permission to practice to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

4.7 Application Form:

(a) The application forms for both initial and renewed permission to practice as an Allied Health Professional shall require detailed information concerning the applicant's professional qualifications. The Allied Health Professional applications existing now and as may be revised are incorporated by reference and made a part of this Policy. In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant's clinical privileges, scope of practice, permission to practice, and/or affiliation has ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, reduced, subjected to probationary or other conditions, limited, terminated, or not renewed at any hospital or health care facility, or is currently being investigated or challenged;

(2) information as to whether the applicant's license or certification to practice any profession in any state or Drug Enforcement Administration registration is or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted, or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience and/or any professional misconduct proceedings involving the applicant, in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the Credentials Committee, Medical Executive Committee or Board may deem appropriate;

(4) current information regarding the applicant's ability to perform, safely and competently, the clinical privileges requested and the duties of Allied Health Professionals; and

(5) a copy of government-issued photo identification.

(b) The applicant shall sign the application and certify that he or she is able to perform the clinical privileges requested and the responsibilities of Allied Health Professionals.

4.8 Grant of Immunity and Authorization to Obtain/Release Information:

By applying for permission to practice at the Hospital, Allied Health Professionals expressly accept the following conditions (i) during the processing and consideration of the application, whether or not permission to practice is granted, (ii) as a condition of continued permission to practice, if granted, (iii) should permission to practice be revoked, reduced, suspended, and/or otherwise affected for reasons related to clinical competence or professional conduct, and (iv) with regard to any third-party inquiries received after the individual leaves about his or her tenure at the Hospital:

(a) Immunity:

To the fullest extent permitted by law, the Allied Health Professional releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, any member of the Medical Staff, their authorized representatives, and third parties who provide information for any matter relating to permission to practice, clinical privileges, scope of practice at the Hospital, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Hospital, its authorized agents, or appropriate third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

The Allied Health Professional specifically authorizes the Hospital, Medical Staff leaders, and their authorized representatives (1) to consult with any third party

who may have information bearing on the Allied Health Professional's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for permission to practice at the Hospital, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of third parties that may be relevant to such questions. The Allied Health Professional also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request, and agrees to sign any necessary consents to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

The Allied Health Professional also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, permission to practice, scope of practice, and/or participation status at the requesting organization/facility, and any license or regulatory matter.

(d) Procedural Rights:

The Allied Health Professional agrees that the procedural rights set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(e) Legal Actions:

If, notwithstanding the provisions in this Section, an Allied Health Professional institutes legal action and does not prevail, he or she shall reimburse the Hospital and any of its authorized representatives named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

ARTICLE 5

CREDENTIALING PROCEDURES

5.1 Request for Application:

(a) Applications for permission to practice at the Hospital shall be in writing and shall be on forms approved by the Board upon recommendation by the Medical Executive Committee and Credentials Committee.

(b) Any individual requesting an application for permission to practice at the Hospital shall be sent a letter that outlines the eligibility criteria for permission to practice, as well as any eligibility requirements that relate to the Allied Health Professional's specific area of practice, and the application form.

(c) Allied Health Professionals who are in a category of practitioners that has not been approved by the Board for access to the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 7 of this Policy.

5.2 Initial Review of Application:

(a) A completed application, with copies of all required documents, must be submitted to the Medical Staff Office within 30 days after receipt of the application if the Allied Health Professional desires further consideration. The application must be accompanied by the application processing fee, if one is required.

(b) As a preliminary step, the Medical Staff Office shall review all applications to determine that all questions have been answered and that the individual satisfies all threshold criteria. Individuals who fail to return completed applications or fail to meet the eligibility criteria set forth in Section 4.1 (a-j) of this Policy will be notified that they are not eligible for permission to practice at the Hospital and that their application will not be processed. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 7 of this Policy.

(c) The Medical Staff Office shall review the application to determine if all questions have been answered, all references and other information or materials have been received, and pertinent information provided on the application has been verified with primary sources. Thereafter, the completed application and all supporting materials shall be transmitted to the applicable department chair.

5.3 Department Chair Procedure:

(a) The Medical Staff Office shall transmit the complete application and all supporting materials to the appropriate department chair or the individual to whom the department chair has assigned this responsibility. Each chair shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for permission to practice and the clinical privileges or scope of practice requested. As part of the process of making this report, the department chair has the right to meet with the applicant and the supervising physician (if applicable) to discuss any aspect of the application, qualifications, and requested clinical privileges or scope of practice. The department chair may also confer with experts within the clinical department and outside of the department in preparing the report (e.g., other physicians, relevant Hospital department heads, nurse managers). In the event that the department chair or the individual to whom the department chair has assigned the responsibility is unavailable or unwilling to prepare a written report, the Chair of the Credentials Committee or the President of the Medical Staff shall appoint an individual to prepare the report.

(b) The department chair shall be available to the Credentials Committee, Medical Executive Committee, or the Board to answer any questions that may be raised with respect to that chair's report and findings.

5.4 Credentials Committee Procedure:

(a) The Credentials Committee shall review the report from the appropriate department chair and the information contained in references given by the applicant and from other available sources. The Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine whether the applicant has established and satisfied all of the necessary qualifications for the clinical privileges or scope of practice requested.

(b) The Credentials Committee may use the expertise of any individual on the Medical Staff or in the Hospital, or an outside consultant, if additional information is required regarding the applicant's qualifications. The Credentials Committee may also meet with the applicant and, when applicable, the supervising physician. The appropriate department chair may participate in this interview.

(c) After determining that an applicant is otherwise qualified for permission to practice and the clinical privileges or scope of practice requested, the Credentials Committee shall review the applicant's Health Status Confirmation form to determine if there is any question about the applicant's ability to perform the clinical privileges or scope of practice requested and the responsibilities of permission to practice. If so, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s)

satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered an incomplete application and all processing of the application shall cease.

5.5 Medical Executive Committee Procedure:

(a) At its next meeting, after receipt of the written findings and recommendations of the Credentials Committee, the Medical Executive Committee shall:

(1) adopt the findings and recommendations of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or

(3) state its reasons in its report and recommendation, along with supporting information for its disagreement with the Credentials Committee's recommendation.

(b) If the Medical Executive Committee's recommendation is favorable to the applicant, the Committee shall forward its recommendation to the Board, through the President of the Medical Staff, including the findings and recommendation of the department chair and the Credentials Committee. The Medical Executive Committee's recommendation must specifically address the clinical privileges or scope of practice requested by the applicant, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges or scope of practice.

(c) If the Medical Executive Committee's recommendation would entitle the applicant to the procedural rights set forth in this Policy, the Medical Executive Committee shall forward its recommendation to the Chief Executive Officer who shall notify the applicant of the recommendation and his or her procedural rights. The Chief Executive Officer shall then hold the Medical Executive Committee's recommendation until after the individual has completed or waived the procedural rights outlined in this Policy.

5.6 Board Action:

(a) The Board may delegate to a committee, consisting of at least two Board members, action on applications if there has been a favorable recommendation from the Credentials Committee and the Medical Executive Committee (or their designees) and there is no evidence of any of the following:

(1) a current or previously successful challenge to any license, certification, or registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of permission to practice, clinical privileges or scope of practice at any other hospital or other entity; or

(3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board Committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

(b) When there has been no delegation to a Board committee, upon receipt of a favorable recommendation concerning an individual, the Board may:

(1) grant the applicant permission to practice and clinical privileges or scope of practice as recommended; or

(2) refer the matter back to the Credentials Committee or Medical Executive Committee or to another source inside or outside the Hospital for additional research or information; or

(3) reject or modify the recommendation.

(c) If the Board determines to reject a favorable recommendation, it will first discuss the matter with the Chair of the Credentials Committee and the President of the Medical Staff. If the Board's determination remains unfavorable, the Chief Executive Officer shall notify the applicant of its determination and the applicant's procedural rights as outlined in this Policy.

5.7 Renewal of Permission to Practice:

(a) Renewal of an Allied Health Professional's clinical privileges or scope of practice shall be considered only upon submission of a completed application for renewed permission to practice. Six months prior to the date of expiration of an Allied Health Professional's clinical privileges or scope of practice, the Medical Staff Office shall give the individual special notice of the date of expiration and an application form for renewed clinical privileges or scope of practice.

(b) Failure to return a completed application to the Medical Staff Office within 30 days will result in the assessment of a reappointment processing fee. In addition, failure to submit an application at least two months prior to the expiration of the individual's current term shall result in automatic expiration of permission to

practice and clinical privileges or scope of practice at the end of the then current term, and the individual may not practice until an application is processed.

(c) Renewed permission to practice, if granted, shall be for a period of not more than two years.

(d) Once an application for renewed permission to practice has been completed and submitted to the Medical Staff Office, it shall be evaluated in the same manner and follow the same procedures outlined in this Policy for initial applicants.

(e) As part of the process for renewal of clinical privileges for Category I and Category II practitioners, the following factors shall be considered:

(1) the competency of the practitioner as assessed by the appropriate department chair or designee and documented on a biennial evaluation form;

(2) a recommendation from a peer; and

(3) use of the Hospital's facilities, taking into consideration practitioner-specific information concerning other individuals in the same or similar specialty.

(f) As part of the process for renewal of a Category III practitioner's scope of practice, the annual competency assessments of the individual performed by the Supervising Physician(s) and/or the applicable Hospital department heads or nurse managers shall be considered. These evaluation forms, along with other reasonable indicators of continuing qualifications, shall be factors for the renewal of Category III practitioners' continued permission to practice.

(g) Applicants seeking renewal of clinical privileges or scope of practice who are the subject of an adverse recommendation shall be entitled to the procedural rights outlined in Article 8 before the Board takes final action.

ARTICLE 6

CONDITIONS OF PRACTICE APPLICABLE TO
CATEGORY II AND CATEGORY III PRACTITIONERS

6.1 Supervision by Supervising Physician:

(a) Any activities permitted by the Board to be performed at the Hospital by a Category II or Category III practitioner shall be performed only under the supervision or direction of the Supervising Physician. Except as provided by law or Hospital policy, "direct supervision" shall not require the actual physical presence of the employing or Supervising Physician.

(b) Category II and Category III practitioners may function in the Hospital only so long as (i) they are supervised by a Supervising Physician, and (ii) they have a current, written supervision agreement with that physician. In addition, should the Medical Staff appointment or clinical privileges of the Supervising Physician be revoked or terminated, the Category II or Category III practitioner's permission to practice at the Hospital and clinical privileges or scope of practice shall be automatically relinquished (unless the individual will be supervised by another physician on the Medical Staff).

(c) As a condition for permission to practice at the Hospital, each Category II or Category III practitioner and his/her Supervising Physician must submit a copy of their written supervision agreement to the Hospital. This agreement must meet the requirements of all applicable state statutes and regulations, as well as any additional requirements of the Hospital. It is also the responsibility of the Category II or Category III practitioner and his/her Supervising Physician to provide the Hospital, in a timely manner, with any revisions or modifications that are made to the agreement.

6.2 Questions Regarding Authority of a Category II or Category III Practitioner:

(a) Should any Medical Staff member or Hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of a Category II or Category III practitioner either to act or to issue instructions outside the physical presence of the Supervising Physician in a particular instance, the Medical Staff member or Hospital employee shall have the right to require that the individual's Supervising Physician validate, either at the time or later, the instructions of the Category II or Category III practitioner. Any act or instruction of the Category II or Category III practitioner shall be delayed until such time as the staff member or Hospital employee can be certain that the act is clearly within the scope of the individual's clinical privileges or scope of practice as permitted by the Board.

(b) Any question regarding the clinical practice or professional conduct of a Category II or Category III practitioner shall be immediately reported to the President of the Medical Staff, the relevant department chair, or the Chief Executive Officer, who shall undertake such action as may be appropriate under the circumstances. The individual to whom the concern has been reported shall also discuss the matter with the Supervising Physician.

6.3 Responsibilities of Supervising Physician:

(a) The Supervising Physician shall be responsible for the actions of the Category II or Category III practitioner in the Hospital.

(b) The number of Category II or Category III practitioners acting under the supervision of one physician, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Physician shall make all appropriate filings with the State Board of Medicine regarding the supervision and responsibilities of the Category II or Category III practitioner, to the extent that such filings are required.

(c) It shall be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the Category II or Category III practitioner in amounts required by the Board that covers any activities of the individual at the Hospital, and to furnish evidence of such coverage to the Hospital. The Category II or Category III practitioner shall act at the Hospital only while such coverage is in effect.

ARTICLE 7

PEER REVIEW PROCEDURES FOR QUESTIONS
INVOLVING ALLIED HEALTH PROFESSIONALS

7.1 Collegial Intervention:

(a) As part of the Hospital's performance improvement and professional and peer review activities, this Policy encourages the use of collegial intervention and progressive steps by Medical Staff leaders and Hospital administration to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised. Collegial intervention efforts are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.

(b) Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.

7.2 Administrative Suspension:

(a) The President of the Medical Staff, the relevant department chair, the Medical Director, the VPMA, and the Chief Executive Officer shall each have the authority to impose an administrative suspension of all or any portion of the clinical privileges or scope of practice of any Allied Health Professional whenever a concern has been raised about such individual's clinical practice or conduct.

(b) An administrative suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer and the President of the Medical Staff, and shall remain in effect unless or until modified by the Chief Executive Officer or the Medical Executive Committee.

(c) Upon receipt of notice of the imposition of an administrative suspension, the Chief Executive Officer and the President of the Medical Staff shall forward the matter to the full Medical Executive Committee, which shall review and consider the question(s) raised and thereafter make an appropriate recommendation to the Board. If the Medical Executive Committee's recommendation is to restrict or terminate the Allied Health Professional's clinical privileges, the individual and, when applicable, the Supervising Physician shall be entitled to the procedural rights outlined in Article 8 of this Policy before the Medical Executive Committee's recommendation is considered by the Board.

7.3 Automatic Relinquishment of Clinical Privileges:

The clinical privileges of an Allied Health Professional shall be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, in the following circumstances:

(a) the Allied Health Professional no longer satisfies all of the threshold eligibility criteria set forth in Section 4.1(a-j) or any additional threshold credentialing qualifications set forth in the specific Hospital policy relating to his or her discipline;

(b) the Medical Staff appointment or clinical privileges of a Supervising Physician supervising a Category II or Category III practitioner is revoked or terminated for any reason (unless the Category II or Category III practitioner will be supervised by another Medical Staff member);

(c) a Category II or Category III practitioner ceases to be directly supervised by a Medical Staff member for any reason (unless the Category II or Category III practitioner will be supervised by another Medical Staff member);

(d) the revocation, limitation, suspension, or lapse of an Allied Health Professional's license, certification, DEA registration, and/or insurance coverage;

(e) an Allied Health Professional's termination, exclusion, or preclusion from participation in the Medicare or Medicaid program by action of the government;

(f) an Allied Health Professional's indictment, conviction, or plea of guilty or no contest to any felony; or to any misdemeanor involving violations of law pertaining to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;

(g) the Allied Health Professional fails to provide information pertaining to his or her qualifications for the scope of practice or clinical privileges in response to a written request from the Credentials Committee, the Medical Executive Committee, the Chief Executive Officer, or any other committee authorized to request such information; or

(h) a determination is made that there is no longer a need for the services that are being provided by the Allied Health Professional.

7.4 Leave of Absence:

(a) An Allied Health Professional may request a leave of absence, for a period not to exceed a year, by submitting a written request to the Chief Executive Officer. The Chief Executive Officer will determine whether a request for a leave of absence shall be granted.

(b) Allied Health Professionals must report to the Chief Executive Officer anytime they are away from patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the Chief Executive Officer, in consultation with the President of the Medical Staff, may trigger an automatic leave of absence.

(c) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital, at least 30 days prior to the conclusion of the leave of absence. If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges or scope of practice requested.

(d) Requests for reinstatement shall then be reviewed by the relevant department chair, the Chair of the Credentials Committee, the President of the Medical Staff, the VPMA, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Medical Executive Committee, and Board for review and recommendation. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to the procedural rights set forth in Article 8 of this Policy.

ARTICLE 8

PROCEDURAL RIGHTS FOR ALLIED HEALTH PROFESSIONALS

8.1 General:

Allied Health Professionals shall not be entitled to the hearing and appeals procedures set forth in the Credentials Policy. Any and all procedural rights to which these individuals are entitled are set forth in this Article.

8.2 Procedural Rights for Employed Allied Health Professionals:

(a) Except as provided in (b), any and all issues related to disciplinary matters involving Category I, Category II, or Category III practitioners who are employed by the Hospital shall be handled in accordance with applicable Human Resources grievance procedures and/or the terms of any applicable employment contract.

(b) If the disciplinary action in question is recommended by the Medical Staff, the provisions of this Article 8 shall be followed and a report provided to Human Resources.

8.3 Procedural Rights for Category III Practitioners:

(a) In the event that a recommendation is made by the Medical Executive Committee that a Category III practitioner not be granted the scope of practice requested, or that the scope of practice previously granted be restricted, terminated, or not renewed, the individual shall be notified of the recommendation. The notice shall include a general statement of the reasons for the recommendation and shall advise the individual that he or she may request a meeting with the Medical Executive Committee before its recommendation is forwarded to the Board.

(b) If a meeting is requested, the meeting shall be scheduled to take place within a reasonable time frame. The meeting shall be informal and shall not be considered a hearing. The Supervising Physician and the Category III practitioner shall both be permitted to attend this meeting. However, no counsel for either the Category III practitioner or the Medical Executive Committee shall be present.

(c) Following this meeting, the Medical Executive Committee shall make its final recommendation to the Board.

8.4 Procedural Rights for Category I and Category II Practitioners:

(a) In the event that a recommendation is made by the Medical Executive Committee that a Category I or Category II practitioner not be granted the clinical privileges requested, or that the clinical privileges previously granted be restricted,

terminated, or not renewed, the practitioner shall be notified of the recommendation. The notice shall include the specific reasons for the recommendation and shall advise the individual that he or she may request a hearing before the adverse recommendation is transmitted to the Board for final action.

(b) If the Category I or Category II practitioner desires to request a hearing, he or she must make such request in writing and direct it to the Chief Executive Officer within 30 days after receipt of the written notice of the adverse recommendation.

(c) If a request for a hearing is made in a timely manner, the Chief Executive Officer, in conjunction with the President of the Medical Staff, shall appoint an Ad Hoc Committee composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, Allied Health Professionals, Hospital management, individuals not connected to the Hospital, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to the Hospital. The Ad Hoc Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Category I or Category II practitioner, or any competitors of the affected individual.

(d) As an alternative to the Ad Hoc Committee described in paragraph (c) of this Section, the Chief Executive Officer, in conjunction with the President of the Medical Staff, may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Ad Hoc Committee. The Hearing Officer shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients who are in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of an Ad Hoc Committee, all references in this Article to the Ad Hoc Committee shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

(e) The hearing shall be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

8.5 Hearing Process for Category I and Category II Practitioners:

(a) At the hearing, a representative of the Medical Executive Committee shall first present the reasons for the recommendation. The Category I or Category II practitioner shall be invited to present information, both orally and in writing, to refute the reasons for the recommendation, subject to a determination by the Presiding Officer (or the Hearing Officer) that the information is relevant. The Presiding Officer (or the Hearing Officer) shall have the discretion to determine

the amount of time allotted to the presentation by the representative of the Medical Executive Committee and the Category I or Category II practitioner.

(b) Both parties shall have the right to present witnesses. The Presiding Officer (or Hearing Officer) shall permit reasonable questioning of such witnesses.

(c) The Category I or Category II practitioner and the Medical Executive Committee may be represented at the hearing by legal counsel, provided, however, that while counsel may be present at the hearing, counsel shall not call, examine, and cross-examine witnesses nor present the case.

(d) The affected practitioner shall have the burden of demonstrating that the recommendation of the Medical Executive Committee was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital shall be the paramount considerations.

(e) Minutes of this proceeding shall be kept and shall be attached to the report and recommendation of the Ad Hoc Committee.

8.6 Ad Hoc Committee or Hearing Officer Report:

(a) The Ad Hoc Committee (or the Hearing Officer) shall prepare a written report and recommendation within 30 days after the conclusion of the proceeding, and shall forward it along with all supporting information to the Chief Executive Officer. The Chief Executive Officer shall send a copy of the written report and recommendation, via certified mail, return receipt requested, to the Category I or Category II practitioner. A copy shall also be provided to the Medical Executive Committee.

(b) Within ten days after receiving notice of the recommendation, either the Category I or Category II practitioner or the Medical Executive Committee may make a request for an appeal. The request must be in writing and must include a statement of the reasons for appeal, including the specific facts, which justify further review. The request shall be delivered to the Chief Executive Officer either in person or by certified mail.

(c) If a written request for appeal is not submitted within the ten day time frame specified above, the recommendation and supporting information shall be forwarded by the Chief Executive Officer to the Board for final action. If a timely request for appeal is submitted, the Chief Executive Officer shall forward the report and recommendation, the supporting information, and the request for appeal to the Chairman of the Board.

8.7 Appeals Process for Category I and Category II Practitioners:

(a) The grounds for appeal shall be limited to the following assertions: (1) there was substantial failure to comply with this Policy and/or other applicable bylaws or policies of the Hospital or the Medical Staff and/or (2) the recommendation was arbitrary, capricious, or not supported by evidence.

(b) The Chairman of the Board, or a committee of the Board appointed by the Chairman, will consider the record upon which the adverse recommendation was made. New or additional written information that is relevant and could not have been made available to the Presiding Officer (or Hearing Officer) may be considered at the discretion of the Chairperson or the appellate review committee. This review shall be conducted within 30 days after receiving the request for appeal.

(c) The Category I or Category II practitioner and the Medical Executive Committee shall each have the right to present a written statement in support of its position on appeal.

(d) At the sole discretion of the Chairman of the Board or the committee appointed by the Chairman, the Category I or Category II practitioner and a representative of the Medical Executive Committee may also appear personally to discuss their position. In that event, however, neither party shall be represented by counsel at the appeal.

(e) Upon completion of the review, the Chairman of the Board or the committee appointed by the Chairman shall provide a report and recommendation to the full Board for action. The Chairman (or the committee) may also refer the matter to any committee or individual deemed appropriate for further review and recommendation to the full Board. The Board shall then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital.

(f) The Category I or Category II practitioner shall receive special notice of the Board's action. A copy of the Board's final action will also be sent to the Medical Executive Committee and to the Credentials Committee for information.

ARTICLE 9

HOSPITAL EMPLOYEES

(a) A request for clinical privileges, on an initial basis or for renewal, submitted by a Category I or Category II practitioner who is seeking employment or who is employed by the Hospital will be processed in accordance with the terms of Article 5 of this Policy. The findings of the Board regarding each individual's qualifications will be forwarded to Hospital management personnel or Human Resources (as appropriate) to assist the Hospital in making employment decisions.

(b) All Category III practitioners listed in Appendix C who are seeking employment or who are employed by the Hospital shall be evaluated by Human Resources through Human Resources processes and procedures, but they must meet the qualifications set forth in Section 4.1 of this Policy.

(c) Except as provided in paragraph (d) below, any disciplinary concern or action with respect to an employed Allied Health Professional will be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship and/or written contract. If an Allied Health Professional's employment is terminated by the Hospital for any reason, the individual's permission to practice in the Hospital will automatically expire without any procedural rights set forth in this Policy.

(d) If a concern about an employed Allied Health Professional's clinical competence or conduct originates with the Medical Staff, the concern will be reviewed and addressed in accordance with Articles 7 and 8 of this Policy, after which a report will be provided to Human Resources.

(e) Except as otherwise provided above, to the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals, and descriptions and terms of the individual's employment relationship and/or written contract will apply.

ARTICLE 10

AMENDMENTS

This Policy may be amended by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Medical Executive Committee. Notice of all proposed amendments shall be posted on the Medical Staff bulletin board at least 14 days prior to the Medical Executive Committee meeting and any member of the Medical Staff may submit written comments to the Medical Executive Committee. No amendment shall be effective unless and until it has been approved by the Board.

ARTICLE 11

ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Medical Staff bylaws, rules and regulations, or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: _____

Approved by the Board: 06-23-08
Amended by the Board: 02-16-12

APPENDIX A

Those individuals currently practicing as Category I practitioners are as follows:

Licensed Clinical Psychologists

APPENDIX B

Those individuals currently practicing as Category II practitioners at the Hospital are as follows:

Certified Nurse Midwives
Certified Nurse Practitioners
Certified Registered Nurse Anesthetists
Physician Assistants

APPENDIX C

Those individuals currently practicing as Category III practitioners at the Hospital are as follows:

Certified First Assistants
Certified Surgical Assistants
Certified Surgical Technologists
Dental Assistants
Hospitalist Coordinator
Registered Nurse First Assistants
Registered Nurses