MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF MUNSON MEDICAL CENTER

POLICY ON ADVANCED PRACTICE PROVIDERS AND OTHER PRACTITIONERS

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

Except as specifically defined below, the definitions that apply to the terms used in this Policy are set forth in the Medical Staff Credentials Policy:

(1) "ADVANCED PRACTICE PROVIDERS" or "APPs" means a type of provider who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who may be required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Collaborating/Supervising Physician pursuant to a written supervision, collaborative, or practice agreement. See Appendix B.

(2) "ALLIED HEALTH PROFESSIONALS" or "AHPs" means a type of provider who is permitted by law or the Hospital to function pursuant to a defined scope of practice. Except as noted in this Policy, all aspects of the clinical practice of Allied Health Professionals at the Hospital shall be assessed and managed by Human Resources in accordance with Human Resources policies and procedures. See Appendix C.

(3) "COLLABORATING/SUPERVISING PHYSICIAN" means a member of the Medical Staff with clinical privileges, who has agreed to supervise, collaborate with, participate with, or functions within a practice or collaborative agreement with, an APP and to accept responsibility for the actions of the APP while he or she is practicing in the Hospital.

(4) "COLLABORATION/SUPERVISION" means the supervision of, collaboration with, participation with, or functioning within the terms of a practice or collaborative agreement with, an APP by a Collaborating/Supervising Physician, that may or may not require the actual presence of the Collaborating/Supervising Physician, but that does require, at a minimum, that the Collaborating/Supervising Physician be readily available for consultation as defined in the Medical Staff rules, regulations, and policies. The requisite level of Collaboration/Supervision shall be determined at the time each APP is credentialed and shall be consistent with any applicable written supervision, collaboration, or practice agreement that may exist.

(5) "LICENSED INDEPENDENT PRACTITIONER" or "LIP" means a type of provider who is permitted by law and by the Hospital to provide patient care services without direction or Collaboration/Supervision, within the scope of his or her license and consistent with the clinical privileges granted. See Appendix A.

(6) "PERMISSION TO PRACTICE" means the authorization granted to an LIP or APP to practice at the Hospital.

1.B. DELEGATION OF FUNCTIONS

(1) When an administrative function under this Policy is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or Hospital employee (or a committee of such individuals). Any such designee is bound by all the terms, conditions and requirements of this Policy. However, the delegating individual or committee is responsible for ensuring the designee performs the function as required by this Policy.

(2) When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2

SCOPE AND OVERVIEW OF POLICY

2.A. SCOPE OF POLICY

(1) This Policy addresses those Licensed Independent Practitioners ("LIPs") and Advanced Practice Providers ("APPs") who are permitted to provide patient care services in the Hospital and are listed in the Appendices to this Policy.

(2) 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 LIPs and APPs at the Hospital.

2.B. CATEGORIES OF LIPs AND APPs

(1) Only those specific categories of LIPs and APPs that have been approved by the Board shall be permitted to practice at the Hospital.

(2) Current listings of the specific categories of LIPs and APPs functioning in the Hospital are attached to this Policy as Appendices. The Appendices may be modified or supplemented by action of the Board, after receiving the recommendation of the MEC, without the necessity of further amendment of this Policy.

2.C. ADDITIONAL POLICIES

The Board shall adopt a separate credentialing protocol for each category of LIPs and APPs that it approves to practice in the Hospital. These separate protocols shall supplement this Policy and shall address the specific matters set forth in Section 3.B of this Policy.

ARTICLE 3

GUIDELINES FOR DETERMINING THE NEED FOR
NEW CATEGORIES OF LIPs AND APPs

3.A. DETERMINATION OF NEED

(1) Whenever a practitioner (LIP, APP) in a category that has not been approved by the Board requests permission to practice at the Hospital, the Board shall ask the Credentials Committee to evaluate the need for that particular category of LIPs and APPs, and to make a recommendation to the MEC for its review and recommendation and then to the Board for final action.

(2) As part of the process of determining need, the individual requesting permission to practice 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.

(3) The Credentials Committee will review any information submitted by the individual requesting permission to practice and consider the following factors:

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

(b) any state license or regulation which outlines the scope of practice that the practitioner is authorized by law to perform;

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

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

(e) the community's needs and whether those needs are currently being met or could be better met if the services offered by the practitioner were provided at the Hospital;

(f) the type of training that is necessary to perform the services that would 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 and monitor quality of care.

(4) The Credentials Committee will then forward its recommendation on whether there is a need for the particular category of practitioner at the Hospital to the MEC, which will review the matter and forward its recommendation to the Board for final action.

3.B. DEVELOPMENT OF POLICY

(1) If the Credentials Committee determines that there is a need for the particular category of practitioner at the Hospital, the committee shall recommend to the MEC and the Board a separate policy for these practitioners that addresses:

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

(b) a detailed description of their authorized scope of practice or clinical privileges;

(c) any specific conditions that apply to their functioning within the Hospital beyond those set forth in this Policy; and

(d) any Collaboration/Supervision requirements, if applicable.

(2) In developing such policies, the Credentials Committee shall consult the appropriate department chair(s) or section chiefs and consider relevant state law and may contact applicable professional societies or associations. The Credentials Committee may also recommend to the Board the number of practitioners that are needed in a particular category.

ARTICLE 4

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

4.A. QUALIFICATIONS

4.A.1. Eligibility Criteria:

To be eligible to apply for initial and continued permission to practice at the Hospital, LIPs and APPs must, where applicable to their practice:*

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

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

(c) be located (office and/or residence) close enough to fulfill Hospital and any assigned Medical Staff responsibilities;

(d) have current, valid professional liability insurance coverage in such form and in amounts determined by the Board;

(e) have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

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

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

(h) have never relinquished or resigned affiliation, clinical privileges, or a scope of practice during an investigation or in exchange for not conducting such an investigation;

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

(j) satisfy all additional eligibility qualifications relating to their specific area of practice that may be established by the Hospital;

(k) document compliance with any health screening requirements (i.e., TB testing, mandatory flu vaccines, and infectious agent exposures); and

(l) if seeking to practice as an APP, have a supervision, collaborative, and/or practice agreement with a physician who is appointed to the Medical Staff (the "Collaborating/Supervising Physician").

* The threshold eligibility criteria outlined in Section 4.A.1 will be applicable to those individuals who apply for initial permission to practice after the date of adoption of this Policy. Existing members will be governed by the eligibility criteria in effect at the time of their initial grant of permission to practice for a period of two years following the adoption of this Policy, after which time all of the threshold criteria outlined above shall apply.

4.A.2. Waiver of Eligibility Criteria:

(a) Any individual who does not satisfy one or more of the criteria outlined above may request a waiver.

(b) A request for a waiver will be submitted to the Credentials Committee for consideration. The individual requesting the waiver bears the burden of demonstrating **exceptional** circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(c) In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the individual in question, input from the relevant department chair, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the MEC. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(d) The MEC will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(e) No individual is entitled to a waiver or to a hearing if the MEC recommends and/or the Board determines not to grant a waiver.

(f) A determination that an individual is not entitled to a waiver is not a "denial" of permission to practice or clinical privileges.

(g) The granting of a waiver in a particular case does not set a precedent for any other individual or group of individuals.

(h) An application form that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

(i) Except for those waivers granted on a time-limited basis, waivers do not need to be renewed and will remain in effect for the life of the individual's tenure at the Hospital.

4.A.3. Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as applicable, as part of a request for permission to practice, as reflected in the following factors:

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

(b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients, families, and their profession;

(c) ability to safely and competently perform the clinical privileges requested;

(d) good reputation and character;

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

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

4.A.4. No Entitlement to Medical Staff Appointment:

LIPs and APPs shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.

4.A.5. Non-Discrimination Policy:

Neither the Hospital nor the Medical Staff shall discriminate in granting permission to practice and/or clinical privileges on the basis of national origin, culture, race, gender, sexual orientation, gender identity, ethnic background, religion, or disability unrelated to the provision of patient care to the extent the individual is otherwise qualified.

4.B. GENERAL CONDITIONS OF PRACTICE

4.B.1. Assumption of Duties and Responsibilities:

As a condition of permission to practice at the Hospital, all LIPs and APPs shall specifically agree to the following:

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

(b) to abide by all policies, the Code of Conduct Policy, and Rules and Regulations of the Hospital and the Bylaws and policies of the Medical Staff in force during the time the individual is appointed;

(c) to accept committee assignments and such other reasonable duties and responsibilities as may be assigned;

(d) to maintain and monitor a Munson e-mail account, which will be the primary mechanism used to communicate all relevant information to the individual;

(e) to provide valid contact information in order to facilitate practitioner-to-practitioner communication (e.g., mobile phone number or valid answering service);

(f) to inform the Medical Staff Services Department, in writing, of any change in the practitioner's status or any change in the information provided on the practitioner's application form. This information will be provided with or without request, at the time the change occurs, and will include, but not be limited to:

- changes in licensure or certification status, DEA controlled substance authorization, or professional liability insurance coverage;
- changes in the practitioner's status at any other hospital or health care entity as a result of peer review activities;
- knowledge of a criminal investigation involving the practitioner, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;

- exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed;

- any changes in the practitioner's ability to safely and competently exercise clinical privileges or to perform the duties and responsibilities of permission to practice because of health status issues, including, but not limited to, impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the Physician Well Being Committee/Impaired Practitioner Policy); and

- any charge of, or arrest for, driving under the influence ("DUI") (Any DUI incident will be reviewed by the President of the Medical Staff and the MMC CMO so that they may understand the circumstances surrounding it. If they have any concerns after doing so, they will forward the matter for further review under the Physician Well Being Committee/Impaired Practitioner Policy or this Policy.);

(g) to immediately submit to an appropriate evaluation in accordance with the Physician Well Being Committee/Impaired Practitioner Policy;

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

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

(j) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate Collaboration/Supervision;

(k) to refrain from deceiving patients as to the individual's status as an LIP or APP and to always wear proper Hospital identification of his or her name and status;

(l) to seek consultation when appropriate;

(m) to participate in the performance improvement and quality monitoring activities of the Hospital;

(n) to complete, in a timely and legible manner, the medical and other required records, containing all information required by the Hospital and to utilize the electronic medical record as required with respect to health care delivered in the Hospital;

(o) to cooperate with all utilization oversight activities;

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

(q) to satisfy applicable continuing education requirements;

(r) to promptly pay any applicable application fees and/or dues;

(s) to strictly comply with the standards of practice applicable to the functioning of APPs in the inpatient hospital setting, as set forth in Section 6.A of this Policy;

(t) to constructively participate in the development, review, and revision of clinical practice and evidence-based medicine protocols and pathways pertinent to his or her specialty (including those related to national patient safety initiatives and core measures), and to comply with all such protocols and pathways;

(u) to comply with all applicable training and educational protocols that may be adopted by the MEC and approved by the Board, including, but not limited to, those involving electronic medical records, CPOE, the privacy and security of protected health information, infection control, or patient safety; and

(v) that, if there is believed to be an intentional 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. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response that will be reviewed by the applicable department chair and/or section chief, who may refer the matter to the Credentials Committee for consideration, if needed. If this provision is triggered and an intentional misstatement or omission is confirmed by the Credentials Committee, the individual may not reapply for permission to practice for a period of at least two years.

4.B.2. Burden of Providing Information:

(a) Individuals seeking permission to practice or renewal of 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) Individuals seeking permission or renewal of permission to practice 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, all information has been verified from primary sources, and all application fees and dues have been paid. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Whenever

there is a need for new, additional, or clarifying information – outside of the normal, routine credentialing process – the application will not be processed until the information is provided. If the application continues to be incomplete 30 days after the individual has been notified of the need for new, additional, or clarifying information, the application shall be deemed to be withdrawn.

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

4.C. APPLICATION

4.C.1. Information:

(a) The application forms for both initial and renewed permission to practice as an LIP or APP shall require detailed information concerning the applicant's professional qualifications. The application forms existing now and as may be revised are incorporated by reference and made a part of this Policy.

(b) 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, health care facility, or other organization, 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, DEA registration, or any state controlled substance license (if applicable) 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, MEC or Board may deem appropriate; and

(4) current information regarding the applicant's ability to perform, safely and competently, the clinical privileges requested and the duties of an LIP or APP.

(c) The applicant shall sign the application and certify that he or she is able to perform the clinical privileges requested and the responsibilities of LIPs and APPs.

4.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

By requesting an application and/or applying for permission to practice, the individual expressly accepts the following conditions:

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or the Board, their authorized representatives, and third parties for any matter relating to permission to practice, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received in good faith and without malice by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

The individual 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 individual'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 initial and continued 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 individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

The individual 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 permission

to practice, clinical privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

(d) Authorization to Share Information within Munson Healthcare:

The individual specifically authorizes Munson Healthcare to share credentialing and peer review information pertaining to an individual's clinical competence and/or professional conduct among its affiliated entities. This information may be shared at initial grant of permission to practice, renewal of permission to practice, and/or any other time during the individual's affiliation with the Hospital.

(e) Procedural Rights:

The individual agrees that the procedural rights set forth in this Policy are the sole and exclusive administrative remedy with respect to any professional review action taken by the Hospital.

(f) Scope of Section:

All of the provisions in this Section are applicable in the following situations:

(1) whether or not permission to practice or clinical privileges is granted;

(2) throughout the term of any affiliation with the Hospital and thereafter;

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

(4) as applicable, to any third-party inquiries received after the individual leaves the Hospital about his or her tenure at the Hospital.

ARTICLE 5

CREDENTIALING PROCEDURE

5.A. PROCESSING OF INITIAL APPLICATION TO PRACTICE

5.A.1. Request for Application:

(a) Any individual requesting an application for permission to practice at the Hospital will be sent (i) a letter that outlines the eligibility criteria for permission to practice as outlined in this Policy, (ii) any eligibility requirements that relate to the individual's specific area of practice, and (iii) the application form.

(b) An individual who is in a category of practitioners that has not been approved by the Board to practice at the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an individual to the procedural rights outlined in Article 8 of this Policy.

5.A.2. Initial Review of Application:

(a) A completed application, with copies of all required documents, must be submitted to the Medical Staff Services Department within 30 days after receipt of the application if the individual desires further consideration. The application must be accompanied by the application processing fee.

(b) As a preliminary step, the application will be reviewed by the Medical Staff Services Department 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.A.1 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 individual to the procedural rights outlined in Article 8 of this Policy.

(c) The Medical Staff Services Department shall oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received. Once an application is complete, it shall be transmitted, along with all supporting documentation, to the applicable department chair or section chief.

5.A.3. Department Chair and/or Section Chief Procedure:

(a) The Medical Staff Services Department shall transmit the complete application and all supporting materials to the appropriate department chair and/or section chief or the individual to whom the chair has assigned this responsibility. Each chair and/or

section chief shall verify eligibility and prepare a written report (on a form provided by the Medical Staff Services Department) regarding whether the applicant has satisfied all of the qualifications for permission to practice and the clinical privileges requested.

(b) As part of the process of making this report, the department chair and/or section chief has the right to meet with the applicant and the Collaborating/Supervising Physician (if applicable) to discuss any aspect of the application, qualifications, and requested clinical privileges. The department chair and/or section chief may also confer with experts within the department and/or section and outside of the department and/or section in preparing the report (e.g., other physicians, relevant Hospital department heads, nurse managers).

(c) In the event that the department chair and/or section chief 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.

(d) The department chair and/or section chief shall be available to answer any questions that may be raised with respect to that individual's report and findings.

5.A.4. Credentials Committee Procedure:

(a) The Credentials Committee shall review the reports from the appropriate department chair and/or section chief 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 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 Collaborating/Supervising Physician. The appropriate department chair or section chief may participate in this interview.

(c) After determining that an applicant is otherwise qualified for permission to practice and the clinical privileges requested, the Credentials Committee may require the applicant to undergo a physical, mental, and/or behavioral examination by a physician(s) satisfactory to the Credentials Committee if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of permission to practice. In addition, any practitioner who is 70 years of age or older and who applies for clinical privileges (or renewal of clinical privileges) shall be required to undergo an examination as outlined in applicable policy. 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. The cost of the health assessment will be borne by the applicant.

(d) The Credentials Committee may recommend specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of education requirements). The Credentials Committee may also recommend that permission to practice be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

(e) The Credentials Committee's recommendation will be forwarded to the MEC.

5.A.5. MEC Procedure:

(a) At its next meeting, after receipt of the written findings and recommendation of the Credentials Committee, the MEC 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 MEC; or

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

(b) If the MEC'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/or section chief and the Credentials Committee. The MEC's recommendation must specifically address the clinical privileges requested by the applicant, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges.

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

5.A.6. Board Action:

(a) Expedited Board Process. 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 MEC (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 or clinical privileges 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 and grant the clinical privileges requested shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

(b) Full Board Process. When there has been no delegation to a Board committee, upon receipt of a recommendation that the applicant be granted permission to practice and clinical privileges requested, the Board may:

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

(2) refer the matter back to the Credentials Committee or MEC for additional research or information; or

(3) reject or modify the recommendation.

(c) If the Board determines to reject a favorable recommendation, it should 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 to the applicant, the President of the Medical Staff shall promptly send special notice to the applicant that the applicant is entitled to request the procedural rights as outlined in this Policy.

(d) Any final decision by the Board to grant, deny, revise, or revoke permission to practice and/or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

5.B. CLINICAL PRIVILEGES

5.B.1. General:

The clinical privileges recommended to the Board for LIPs and APPs will be based upon consideration of the following factors:

(a) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families and other members of the health care team and peer evaluations relating to the same;

(b) ability to perform the privileges requested competently and safely;

(c) information resulting from ongoing and focused professional practice evaluation and performance improvement activities, as applicable;

(d) adequate professional liability insurance coverage for 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 or involuntary relinquishment of such licensure or registration;

(g) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

(h) practitioner-specific data as compared to aggregate data, when available;

(i) morbidity and mortality data, when available; and

(j) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

5.B.2. FPPE to Confirm Competence and Professionalism:

All new clinical privileges for LIPs and APPs, regardless of when they are granted (initial permission to practice, renewal of permission to practice, or at any time in between), will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE process for these situations is outlined in the relevant Medical Staff policy.

5.C. TEMPORARY CLINICAL PRIVILEGES

5.C.1. Request for Temporary Clinical Privileges:

(a) Applicants. Temporary privileges for an applicant for initial permission to practice may be granted by the CEO, upon recommendation of the President of the Medical Staff and the department chair or section chief, when an LIP or APP has submitted a completed application and the application is pending review by the MEC and the Board. Prior to temporary privileges being granted in this situation, the credentialing process must be complete, including, where applicable, verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and compliance with criteria, and consideration of information from the National Practitioner Data Bank and from a criminal background check. In order to be eligible for temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and that he or she has not been subject to involuntary termination of membership, or involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility.

(b) Locum Tenens. The CEO, upon recommendation of the President of the Medical Staff and the applicable department chair or section chief, may grant temporary privileges to an LIP or APP serving as a locum tenens for an individual who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time. Prior to temporary privileges being granted in this situation, the practitioner must meet the relevant eligibility criteria outlined in Section 4.A.1 of this Policy and the verification process must be complete, including, where applicable, verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and compliance with criteria, and consideration of information from the National Practitioner Data Bank and from a criminal background check. In order to be eligible for temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and that he or she has not been subject to involuntary termination of membership, or involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility.

(c) Compliance with Bylaws and Policies. Prior to temporary privileges being granted, the individual must agree in writing to be bound by all applicable bylaws, rules and regulations, and policies, procedures, and protocols.

(d) Time Frames and Automatic Expiration. Temporary privileges will be granted for a specific period of time, not to exceed 120 days, and will expire at the end of the time period for which they are granted.

(e) FPPE. Individuals who are granted temporary privileges will be subject to the Medical Staff policy regarding focused professional practice evaluation.

5.C.2. Withdrawal of Temporary Clinical Privileges:

The CEO may withdraw temporary privileges for any reason, at any time, after consulting with the President of the Medical Staff, the Chair of the Credentials Committee, the department chair, the section chief, or the MMC CMO.

5.D. PROCESSING APPLICATIONS FOR RENEWAL TO PRACTICE

5.D.1. Submission of Application:

(a) The grant of permission to practice will be for a period not to exceed two years. A request to renew clinical privileges will be considered only upon submission of a completed renewal application.

(b) At least three months prior to the date of expiration of an individual's clinical privileges, the Medical Staff Services Department will notify the individual of the date of expiration and provide the individual with a renewal application. A completed renewal application must be returned to the Medical Staff Services Department within 30 days.

(c) Failure to return a completed application within 30 days may result in the assessment of a reappointment late fee, which must be paid prior to the application being processed, and the automatic expiration of clinical privileges at the end of the then current term, unless the application can still be processed in the normal course, without extraordinary effort on the part of the Medical Staff Services Department and the Medical Staff Leaders.

(d) Once an application for renewal of clinical privileges has been completed and submitted, it will be evaluated following the same procedures outlined in this Policy regarding initial applications.

5.D.2. Renewal Process:

(a) The procedures pertaining to an initial request for clinical privileges, including eligibility criteria and factors for evaluation, will be applicable in processing requests for renewal for these practitioners.

(b) As part of the process for renewal of clinical privileges, the following factors will be considered:

(1) an assessment prepared by the applicable department chair and/or section chief;

(2) an assessment prepared by a peer, if possible;

(3) results of the Medical Staff's performance improvement and ongoing and focused professional practice evaluation activities, taking into consideration, when applicable, practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);

(4) resolution of any verified complaints received from patients or staff; and

(5) any focused professional practice evaluations.

(c) For APPs, the following information may also be considered:

(1) an assessment prepared by the Collaborating/Supervising Physician(s); and

(2) an assessment prepared by the applicable Hospital supervisor (i.e., OR Supervisor, Nursing Supervisor).

5.E. ADMINISTRATIVE AND HONORARY STATUSES

An LIP or APP who is exercising no clinical privileges or who is retiring from clinical practice may qualify for Administrative or Honorary status. A request for change in status shall be submitted to the Credentials Committee for consideration. The Credentials Committee may consider the specific qualifications of the individual and input from the relevant department chair and the Hospital. The Credentials Committee's recommendation will be forwarded to the MEC. The MEC shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the status.

5.E.1. Administrative LIPs and APPs

LIPs and APPs who provide administrative services to the Medical Staff and Hospital shall be eligible for this status. Since such status is for administrative purposes only, they shall carry no admitting privileges, no clinical privileges, and no patient responsibilities.

Prerogatives and Responsibilities:

Administrative staff:

(a) may not consult, admit, or attend to patients;

(b) may attend Medical Staff and department meetings (without vote);

(c) may serve on committees (without vote unless he or she also holds a voting position);

(d) are entitled to attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office but may serve as department chairs or committee chairs; and

(f) are not required to pay application fees and dues.

5.E.2. Honorary APPs and LIPs

The Honorary status shall consist of practitioners who have retired from the practice of medicine in this Hospital after serving for more than 10 years, who are in good standing, and who have been recommended by the MEC. Once an individual is granted Honorary status, that status is ongoing. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

Prerogatives and Responsibilities:

Honorary staff:

(a) may not consult, admit, or attend to patients;

(b) may attend Medical Staff and department or section meetings (without vote);

(c) may be invited to serve on committees (with vote);

(d) are entitled to attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office or serve as department chairs or committee chairs (unless waived by the MEC and ratified by the Board); and

(f) are not required to pay application fees and dues.

ARTICLE 6

CONDITIONS OF PRACTICE APPLICABLE TO ADVANCED PRACTICE PROVIDERS

6.A. STANDARDS OF PRACTICE FOR THE UTILIZATION OF APPs IN THE INPATIENT HOSPITAL SETTING

(1) As a condition of being granted permission to practice at the Hospital, all APPs specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of being permitted to utilize the services of APPs in the Hospital, all Medical Staff members who serve as Collaborating/Supervising Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.

(2) The following standards of practice apply to the functioning of APPs in the inpatient Hospital setting unless a waiver or special privileges are otherwise recommended by the Credentials Committee and the MEC and approved by the Board. This is expected to occur rarely and only when exceptional circumstances exist (e.g., there is a demonstrated service need):

(a) Admitting Privileges. APPs are not granted inpatient admitting privileges. However, an APP is permitted to write inpatient admission orders on behalf of a Collaborating/Supervising Physician who has inpatient admitting privileges, so long as the order is cosigned by the Collaborating/Supervising Physician.

(b) Consultations. An APP may see a patient, gather data, order tests, and generate documentation in response to a request for a consultation. However, the Collaborating/Supervising Physician must still personally see the patient if requested by the physician requesting the consultation.

(c) Emergency On-Call Coverage. APPs may participate in the emergency on-call roster and be designated as a Collaborating/Supervising Physician's first contact. If contacted by the Emergency Department Physician, the Collaborating/Supervising Physicians (or their covering physician) must personally respond to all calls in a timely manner. Following discussion with the Emergency Department Physician, the Collaborating/Supervising Physician may direct an APP to see the patient, gather data, order tests, and generate documentation for further review by the Collaborating/Supervising Physician.

6.B. RESPONSIBILITIES OF AND OVERSIGHT BY COLLABORATING/SUPERVISING PHYSICIAN

(1) An APP may function in the Hospital only so long as he or she (i) is appropriately supervised by, collaborating with, or is functioning within a practice agreement with, a Collaborating/Supervising Physician who is currently appointed to the Medical Staff, and (ii) has a current, written supervision, collaborative, or practice agreement with the Collaborating/Supervising Physician. In addition, the Collaborating/Supervising Physician who wishes to utilize the services of an APP in the inpatient setting specifically agrees to abide by the standards of practice set forth in Section 6.A above. Should the Medical Staff appointment or clinical privileges of the Collaborating/Supervising Physician be revoked or terminated, the APP's permission to practice at the Hospital and clinical privileges shall be automatically relinquished (unless the individual will be supervised by or will participate with another physician on the Medical Staff who meets the necessary requirements for such supervision or participation).

(2) Physicians who wish to utilize the services of an APP in their clinical practice at the Hospital must notify the Medical Staff Services Department of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy before the APP participates in any clinical or direct patient care of any kind in the Hospital. As a condition of clinical privileges, an APP and the Collaborating/Supervising Physician must provide the Hospital with a copy of any written supervision, collaborative, or practice agreement that may be required by the state as well as notice of any revisions or modifications that are made to any such agreements between them. This notice must be provided to the Medical Staff Services Department within three days of any such change.

(3) The Collaborating/Supervising Physician will be responsible for all care provided by the APP in the Hospital. Any activities permitted to be performed at the Hospital by an APP shall be performed only in collaboration or participation with, or under the supervision or direction of, a Collaborating/Supervising Physician.

(4) The number of APPs acting in collaboration with, under the supervision of, or functioning within a practice agreement with, a Collaborating/Supervising Physician, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Collaborating/Supervising Physician will make any appropriate filings with the State Board of Medicine regarding the Collaboration/Supervision and responsibilities of the APP, to the extent that such filings are required and shall provide a copy of the same to the Medical Staff Services Department.

ARTICLE 7

QUESTIONS INVOLVING LIPs AND APPs

7.A. PROFESSIONAL PRACTICE EVALUATION ACTIVITIES

Professional practice evaluation activities shall be conducted in accordance with the Medical Staff's professional practice evaluation policies. Matters that are not satisfactorily resolved through collegial intervention efforts or through the Medical Staff's professional practice evaluation policies shall be referred to the MEC for its review in accordance with Section 7.C below. Such interventions and evaluations, however, are not mandatory prerequisites to MEC review.

7.B. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

(1) As part of the Hospital's performance improvement and professional practice evaluation activities, this Policy encourages the use of collegial efforts and progressive steps with LIPs and APPs (and their Collaborating/Supervising Physicians, as applicable) by Medical Staff Leaders and Hospital management in order to arrive at voluntary, responsive actions by individuals to resolve questions that have been raised and validated. Collegial intervention efforts are not mandatory and shall be within the discretion of the appropriate Medical Staff Leaders.

(2) Collegial intervention efforts may include, but are not limited to, counseling, coaching, sharing of comparative data, monitoring, and additional training or education. All such efforts shall be documented in an individual's confidential file.

(3) All of these efforts are fundamental components of the Medical Staff's professional practice evaluation activities and are confidential and protected in accordance with Michigan law.

(4) These efforts are intended to resolve issues in a constructive manner and do not involve the formal hearing process. Accordingly, LIPs and APPs do not have the right to be accompanied by counsel when the Medical Staff leadership is engaged in collegial intervention efforts or other progressive steps. In addition, there shall be no recording (audio or video) of any meetings that involve collegial intervention or progressive steps activities. LIPs and APPs may request that another individual (e.g., Medical Staff member, another LIP, or another APP) be allowed to accompany him or her as an advisor. Any such individual must agree to maintain all information as confidential and should understand that he or she may be removed from the meeting by the Medical Staff leadership if his or her presence or conduct is deemed to be disruptive, provided that a clear warning is first given, requesting that the disruptive actions cease, before he or she is removed.

(5) The Medical Staff Leaders, in conjunction with the CEO or the MMC CMO, shall determine whether to direct that a matter be handled in accordance with another Medical Staff policy or to direct the matter to the MEC for further review and/or investigation.

7.C. FORMAL INVESTIGATIONS

7.C.1. Initiation of a Formal Investigation:

When a question involving clinical competence or professional conduct of an LIP and APP is referred to, or raised by, the MEC, the MEC will review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy, or to proceed in another manner. An investigation shall begin only after the MEC votes to commence a formal investigation (hereinafter a "Formal Investigation").

7.C.2. Formal Investigative Procedure:

(a) The MEC will either investigate the matter itself or appoint an ad hoc committee or individual to conduct the Formal Investigation ("investigating committee"). The investigating committee will not include relatives or financial partners of the individual or, where applicable, the individual's Collaborating/Supervising Physician. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., a practitioner in a similar discipline).

(b) The investigating committee will have the authority to review relevant documents and interview individuals. It will also have available to it the full resources of the Medical Staff and the Hospital.

(c) The investigating committee will also have the authority to use outside consultants, if needed.

(d) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by a health care professional(s) acceptable to it. The individual being investigated shall execute a release (in a form approved or provided by the investigating committee) allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. The cost of such health examination shall be borne by the individual.

(e) The individual will have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed of the general questions being investigated and may submit written questions in advance of the meeting, as may his or her counsel.

(f) At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the Formal Investigation. This meeting is not a hearing, and none of the procedural rules for hearings will apply. A summary of the interview shall be prepared by the investigating committee and included with its report, but no recording (audio or video) or transcript of the meeting shall be permitted or made. The individual being investigated shall have the right to be accompanied by legal counsel at this meeting, who may serve as an advisor to the individual but may not actively participate in the interview. The chair of the investigating committee retains the right to remove the individual's counsel at any time if counsel's presence or conduct is deemed to be disruptive to the meeting, provided that a clear warning is first given, requesting that the disruptive actions cease, before he or she is removed.

(g) The investigating committee will make a reasonable effort to complete the Formal Investigation and issue its report within 30 days of the commencement of the Formal Investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the Formal Investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve only as guidelines.

(h) At the conclusion of the Formal Investigation, the investigating committee will prepare a report with its findings.

7.C.3. Recommendation:

(a) The MEC will review the findings of the investigating committee and may determine that no action is justified or make any recommendation that it deems necessary or appropriate.

(b) A recommendation by the MEC that would entitle the individual to request a hearing will be forwarded to the President of the Medical Staff, who will promptly inform the individual by special notice. The President of the Medical Staff will hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) If the MEC makes a recommendation that does not entitle the individual to request a hearing, it will take effect immediately and will remain in effect unless modified by the Board.

7.D. PRECAUTIONARY SUSPENSION

(1) Any Medical Staff Officer or department chair, acting in conjunction with the MMC CMO or the CEO, OR the MEC will have the authority to impose a precautionary suspension of all or any portion of the clinical privileges of any LIP

or APP whenever a question has been raised about such individual's clinical care or professional conduct.

(2) A precautionary suspension will become effective immediately upon imposition, will immediately be reported in writing to the CEO and the President of the Medical Staff, and will remain in effect unless or until modified by the President of the Medical Staff, in conjunction with the CEO or the MEC. The imposition of a precautionary suspension does not entitle an individual to the procedural rights set forth in Article 8 of this Policy unless the suspension is in effect for more than 15 days.

(3) Upon receipt of notice of the imposition of a precautionary suspension, the CEO and President of the Medical Staff will forward the matter to the MEC, which will review and consider the question(s) raised and thereafter make a recommendation to the Board.

7.E. AUTOMATIC RELINQUISHMENT/ACTIONS

(1) An individual's clinical privileges shall be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, in the following circumstances:

(a) the individual no longer satisfies any of the threshold eligibility criteria set forth in Section 4.A.1 or any additional threshold credentialing qualifications set forth in the specific Hospital policy relating to his or her discipline;

(b) the individual is arrested, charged, indicted, convicted, or enters a plea of guilty or no contest to any felony; or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) child abuse; (v) elder abuse; or (vi) violence against another (DUIs will be addressed in the manner outlined in Section 4.B.1(f) of this Policy);

(c) the individual fails to provide information pertaining to his or her qualifications for clinical privileges in response to a written request from the Credentials Committee, the MEC, the Professional Practice Evaluation Committee, the MMC CMO, the CEO, or any other committee authorized to request such information;

(d) the individual fails to complete and/or comply with training or educational requirements that are adopted by the MEC and approved by the Board, including, but not limited to, those pertinent to electronic medical records, CPOE, the privacy and security of protected health information, infection control, or patient safety;

(e) the individual fails to attend a special meeting at the request of a Medical Staff Leader to discuss a concern with clinical practice or professional conduct;

(f) a Board determination is made that there is no longer a need for the services of a particular discipline or category of LIPs or APPs;

(g) an APP fails, for any reason, to maintain an appropriate relationship with a Collaborating/Supervising Physician as defined in this Policy; or

(h) any individual employed by the Hospital has his or her employment terminated.

(2) Requests for reinstatement.

(a) Requests for reinstatement following the expiration of a license/certification/registration, controlled substance authorization, and/or insurance coverage will be processed by the Medical Staff Services Department. If any questions or concerns are noted, the Medical Staff Services Department will refer the matter for further review in accordance with (b) below.

(b) All other requests for reinstatement shall be reviewed by the relevant department chair, the Chair of the Credentials Committee, the President of the Medical Staff, the MMC CMO, and the CEO. If the determination to reinstate is unanimous, it shall then be forwarded to the Credentials Committee, MEC, 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, MEC, and Board for review and recommendation.

7.F. LEAVE OF ABSENCE

An individual may request a leave of absence in accordance with the Medical Staff's leave of absence policy.

ARTICLE 8

PROCEDURAL RIGHTS FOR LIPs AND APPs

Any and all procedural rights to which LIPs and APPs are entitled are set forth in this Article. These individuals shall not be entitled to the hearing and appeals procedures set forth in the Medical Staff Bylaws.

8.A. NOTICE OF RECOMMENDATION AND HEARING RIGHTS

(1) In the event a recommendation is made by the MEC that an LIP or APP request for clinical privileges be denied or that the privileges previously granted be suspended for more than 15 days or otherwise restricted for a period of more than 30 days, terminated, or not renewed, the individual will receive special notice of the recommendation. The special notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a hearing.

(2) The rights and procedures in this Section will also apply if the Board, without a prior adverse recommendation from the MEC, makes a recommendation not to grant clinical privileges or that the privileges previously granted be restricted, terminated, or not renewed. In this instance, all references in this Article to the MEC will be interpreted as a reference to the Board.

(3) If the LIP or APP wants to request a hearing, the request must be in writing, directed to the President of the Medical Staff, within 30 days after receipt of written notice of the adverse recommendation.

(4) The hearing will 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.B. HEARING COMMITTEE, PRESIDING OFFICER, AND HEARING OFFICER

(1) Hearing Committee and Presiding Officer:

If a request for a hearing is made in a timely manner, the President of the Medical Staff, in conjunction with the CEO, shall appoint a Hearing Committee composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, LIPs, and APPs, Hospital management, practitioners not connected to the Hospital, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to the Hospital. The Hearing Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the LIP or APP, or any competitors of the affected individual.

(2) Hearing Officer:

As an alternative to the Hearing Committee described in paragraph (a) of this Section, the President of the Medical Staff, after consulting with the CEO, may propose the use of a Hearing Officer. This alternative will be presented to the individual requesting the hearing for his or her consideration. If the individual requesting the hearing agrees to the use of a Hearing Officer, the President of the Medical Staff will then appoint a Hearing Officer to perform the functions of a Hearing Panel and the Presiding Officer. The Hearing Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing. In the event a Hearing Officer is appointed, all references in this Article to the Hearing Committee and Presiding Officer shall be deemed to refer instead to the Hearing Officer.

(3) Objections:

Any objection to any member of the Hearing Committee, to the Presiding Officer, or the Hearing Officer shall be made in writing, within 10 days of receipt of notice, to the President of the Medical Staff. A copy of such written objection must be provided to the CEO and must include the basis for the objection. The President of the Medical Staff shall rule on the objection and give notice to the parties. The President of the Medical Staff may request that the Presiding Officer (or another Medical Staff Officer if the Presiding Officer is the subject of the objection) make a recommendation as to the validity of the objection.

8.C. HEARING PROCESS

(1) The hearing shall begin no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties, and will be scheduled for a date and time that is mutually agreeable to all parties.

(2) A record of the hearing will be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript will be available at the individual's expense.

(3) The hearing will last no more than six hours, with each side being afforded approximately three hours to present its case, in terms of both direct and cross-examination of witnesses.

(4) At the hearing, a representative of the MEC will first present the reasons for the recommendation. The LIP or APP will be invited to present information to refute the reasons for the recommendation.

(5) Both parties will have the right to present witnesses. The Presiding Officer will permit reasonable questioning of such witnesses.

(6) The LIP or APP and the MEC may be accompanied at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel will not call, examine, or cross-examine witnesses or present the case.

(7) The LIP or APP will have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the MEC was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital will be the paramount considerations.

(8) The LIP or APP and the MEC will have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The Presiding Officer will establish a reasonable schedule for the submission of such memoranda.

8.D. HEARING COMMITTEE REPORT

(1) Within 20 days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Hearing Committee will prepare a written report and recommendation. The Hearing Committee will forward the report and recommendation, along with all supporting information, to the President of the Medical Staff. The President of the Medical Staff will send a copy of the written report and recommendation by special notice to the LIP or APP and to the MEC.

(2) Within ten days after notice of such recommendation, the LIP or APP and/or the MEC may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.

(3) The grounds for appeal will be limited to an assertion that there was substantial failure to comply with this Policy during the hearing, so as to deny a fair hearing, and/or that the recommendation of the Hearing Committee was arbitrary, capricious, or not supported by substantial evidence.

(4) The request for an appeal will be delivered to the President of the Medical Staff by special notice.

(5) If a written request for appeal is not submitted timely, the appeal is deemed to be waived and the recommendation and supporting information will be forwarded to the Board for final action. If a timely request for appeal is submitted, the President of the Medical Staff will forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chair of the Board will arrange for an appeal.

8.E. APPELLATE REVIEW

(1) An Appellate Review Committee appointed by the Chair of the Board 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 Hearing Committee may be considered at the discretion of the Appellate Review Committee. This review will be conducted within 30 days after receiving the request for appeal.

(2) The LIP or APP and the MEC will each have the right to present a written statement on appeal.

(3) At the sole discretion of the Appellate Review Committee, the LIP or APP and a representative of the MEC may also appear personally to discuss their position.

(4) Upon completion of the review, the Appellate Review Committee will provide a report and recommendation to the full Board for action. The Board will 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.

(5) The LIP or APP will receive special notice of the Board's action. A copy of the Board's final action will also be sent to the MEC for information.

ARTICLE 9

HOSPITAL EMPLOYEES

A. Except as provided below, the employment of LIPs and APPs by the Hospital shall be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship and/or written contract. 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 shall apply.

B. Except as noted in (A), Hospital-employed LIPs and APPs are bound by all of the same conditions and requirements in this Policy that apply to non-Hospital employed LIPs and APPs.

C. A request for clinical privileges, on an initial basis or for renewal, submitted by an LIP or APP practitioner who is seeking employment or who is employed by the Hospital shall be processed in accordance with the terms of this Policy and the Medical Staff leadership shall determine whether the individual is qualified for the privileges requested. A report regarding each practitioner's qualifications shall then be made to Hospital management or Human Resources (as appropriate) to assist the Hospital in making employment decisions.

D. If a concern about an employed LIP's and APP's clinical competence or professional conduct originates with the Medical Staff, the concern may be reviewed and addressed in accordance with Articles 7 and 8 of this Policy, after which a report will be provided to Hospital management or Human Resources (as appropriate). This provision does not preclude Hospital management or Human Resources from addressing an issue in accordance with the Hospital's employment policies/manuals or in accordance with the terms of any applicable employment contract.

ARTICLE 10

AMENDMENTS AND ADOPTION

(a) The amendment process for this Policy is set forth in the Bylaws.

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

Adopted by the Medical Staff: _____

Approved by the Board: _____

APPENDIX A

The categories of LIPs currently practicing at the Hospital are as follows:

Physician in Training at the Fellowship Level

Psychologist, Ph.D.

APPENDIX B

The categories of APPs currently practicing at the Hospital are as follows:

Physician Assistant (PA)

Nurse Practitioner (NP)

Certified Nurse Midwife (CNM)

Certified Registered Nurse Anesthetist (CRNA)

Certified Anesthesiologist Assistant (CAA)

Clinical Nurse Specialist (CNS)

APPENDIX C

The categories of AHPs currently practicing at the Hospital include, but are not limited to:

Audiologist

Dental Assistant

Case Manager

Counselor

Orthotics/Prosthetics

Perfusionist

Social Worker

Surgical Assistant

Technician