HEALTHALLIANCE HOSPITAL: MARY'S AVENUE CAMPUS
BYLAWS OF THE MEDICAL STAFF
PREAMBLE

Mary's Avenue Campus (the "Hospital") is a charitable corporation organized under the laws of the State of New York. Recognizing that the medical staff is responsible for the quality of medical care in the Hospital and must discharge this responsibility in cooperation with the Board of Directors, the physicians, dentists and podiatrists practicing in the Hospital hereby organize themselves into a medical staff in conformity with these bylaws. Such medical staff shall report to the Board of Directors regarding the medical staff's quality assurance and other activities.

ARTICLE I

NAME

The name of this organization is the Medical Staff of the Mary's Avenue Campus.

ARTICLE II

PURPOSES

The purposes of this organization are:

2.1 To strive toward assuring that patient care in the Hospital is consistently maintained at the level of quality and efficiency achievable by the state of healing arts and resources locally available through participation in educational, training, and continuous quality assessment and improvement activities, and through establishment of standards of professional performance.

2.2 To advise Hospital Administration, the Board of Directors and the HA Board of Directors on matters relating to patient care, and to discuss issues concerning the medical staff with Hospital Administration, the Board of Directors and HA Board of Directors.

2.3 To serve the health care needs of the community.

2.4 To provide for the self-governance of the medical staff.

ARTICLE III

DEFINITIONS

3.1 The term "physician" includes duly licensed medical physicians and osteopathic physicians.

3.2 The term "medical staff" means all duly licensed physicians, dentists and podiatrists who have been granted privileges by the HA Board of Directors to attend patients in the Hospital.

3.3 The term "Executive Committee" or "Medical Executive Committee" means the Medical Executive Committee of the medical staff.

3.4 The term "practitioner" means an appropriately licensed physician, dentist or podiatrist (M.D., D.O., D.M.D., D.D.S. or D.P.M.). For purposes of Articles IX and X only of these bylaws, the term "practitioner" shall mean appropriately licensed physicians, dentists and podiatrists who are members of the medical staff and individuals who are members of the allied health professional staff.

3.5 The term "Governing Body" or "Board of Directors" means the Board of Directors of the Hospital.

3.6 The term "President" means the President of the medical staff unless specific reference is made to the President/Chief Executive Officer.

3.7 The term "President/Chief Executive Officer" means the President and Chief Executive Officer of the Hospital.

3.8 "HA Board of Directors" means the Board of Directors of Health Alliance, Inc., the sole corporate member and operator of the Hospital.

3.9 The term "Hospital Administration" means the President/Chief Executive Officer, or, in his absence, the designee of the President/Chief Executive Officer.

3.10 The term "Medical Director" means the physician appointed by the Board of Directors, after consultation with the Medical Staff, to serve as the Medical Director of the Hospital (referred to as the "Chief Medical Officer" of the Hospital), as such position is defined in applicable New York State Department of Health regulations (e.g., Vice President/Medical Staff Services, Vice President of Medical Affairs).

3.11 The term "he" or "his" used throughout this document is considered a generic term appropriate to either men or women, who shall hold equal status in the Hospital. The captions and headings in these bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these bylaws.

3.12 The term "Hospital" means Mary's Avenue Campus.

3.13 "Allied Health Professionals" shall be deemed to include clinical psychologists, certified registered nurse anesthetists, midwives licensed to practice in the State of New York, clinical nurse practitioners, physician assistants, audiologists, radiation physicists, acupuncturists, and other non-medical staff members who are given clinical privileges by the HA Board of Directors in accordance with these Medical Staff Bylaws and related manuals. ***Amended MS 1/14/14***

3.14 The term "Good Standing" as it relates to a staff members is defined as being in compliance with the requirements and responsibilities of Medical Staff membership and the assigned Medical Staff category including, but not limited to, being up-to-date in dues payments and fines, being without disciplinary actions and having no current restriction on Medical Staff membership and clinical privileges. ***Amended MS 3/28/13***

ARTICLE IV

MEDICAL STAFF MEMBERSHIP

4.1 Qualifications for Membership

4.1.1 General. Membership on the medical staff shall be a privilege extended to practitioners who meet the qualifications, standards and requirements set forth in these bylaws. Professional standards and criteria for medical staff membership and clinical privileges will be applied uniformly to all applicants, regardless of age, sex, race, disability, creed, national origin, nationality, sexual orientation or marital status.

4.1.1.1 To be qualified for membership on the medical staff, a practitioner must be licensed to practice Medicine/Surgery, Dentistry, or Podiatry in the State of New York, possess a valid Drug Enforcement Agency registration (unless an exception is recommended by the credentials committee and approved by the Executive Committee), reside within a 25 mile radius of the Hospital (or the part thereof in which privileges are sought) or provide proof of coverage for patients, be able to document his education, training, experience, competence, adherence to the ethics of his profession, and ability to work with others adequately to assure the medical staff, the Board of Directors and the HA Board of Directors that any patient treated by the practitioner in the Hospital will be given a high quality of medical care..

4.1.1.2 Notwithstanding any other provision of these bylaws, any individual who held an appointment on the medical staff or the allied health professional staff of the Hospital immediately prior to the effective date of these bylaws shall automatically be accorded an appointment to the same category of the medical staff or allied health professional staff of the Hospital. Each member who is accorded such an appointment shall be subject to reappointment in accordance with the applicable provisions of these bylaws.

4.1.1.3 Pursuant to the Health Insurance Portability Act (HIPAA), the Hospital has designated itself as an Organized Health Care Arrangement ("OHCA") with its credentialed members of the medical staff and allied health professional staff to expedite the sharing of protected health information (PHI) for treatment, payment, and health care operations of the entire arrangement. The OHCA will allow credentialed members of the medical staff and allied health professional staff to operate under the Hospital's Notice of Privacy Practices and the policies and procedures to support the Notice while they are treating patients within the hospital and participating in meetings where PHI is presented and discussed.

Members of the OHCA are required to comply with the Hospital's Notice of Privacy Practices while working in the Hospital. The HIPAA Privacy Regulations provide that there is no shared liability among the participants in an OHCA. This means that if one individual in the OHCA does not comply with the HIPAA Privacy Regulations, that individual's actions do not make the entire OHCA liable.

4.1.1.4 Practitioners shall be required to seek consultations: (a) in all cases in which the practitioner determines, in his reasonable medical judgment, that (1) the diagnosis is obscure after ordinary diagnostic procedures have been completed; (2) there is doubt as to the best therapeutic measures to be utilized; or (3) patient is not a good medical or surgical risk; (b) in unusually complicated situations where specific skills of other practitioners may be needed;

(c) in instances in which the patient exhibits psychiatric complications that are outside of the attending practitioner's clinical privileges; (d) when requested by the patient or his family; and (e) when requested by the Medical Director; provided, however, that in all events, the need for consultation by a specialist practitioner to provide for the diagnosis and treatment of patient conditions shall be made in accordance with generally accepted standards of patient care; provided further that the foregoing criteria and procedures shall not preclude post-graduate trainees, nurses or other health care practitioners involved in the care of the patient from requesting such consultation in an emergency;

4.1.2 Demonstration of Professional Competence. Each applicant for appointment to the medical staff shall be required to provide evidence of proficiency within his field of practice. Proficiency may be demonstrated by an applicant by submission of:

4.1.2.1 Documentation of current certification by the appropriate medical specialty board as defined by the American Board of Medical Specialties, American Osteopathic Specialty Boards, American Council on Dental Education; or the American Board of Podiatric Surgery, as appropriate;

4.1.2.2 Documentation of qualification as a candidate for board certification or receipt of board certification within the time frame established by the applicable specialty board to be eligible to obtain board certification; or

4.1.2.3 Demonstration and documentation of sufficient clinical experience within the specialty field as recommended by the Department Chair, in conjunction with the credentials committee, the Executive Committee and the Board of Directors, and approved by the HA Board of Directors.

4.2 Categories of Membership. The medical staff shall be divided into provisional, courtesy, active, consulting, adjunct and emeritus categories.

4.2.1 Provisional Staff. Initial appointment to any staff category shall be on a provisional basis in accordance with Section 4.4.1 of these bylaws. A practitioner appointed to the provisional staff shall be subject to the requirements of Sections 4.2.4.1 to 4.2.4.7 but, unless otherwise provided herein, shall not be entitled to vote at medical staff meetings and may not hold medical staff office. Practitioners appointed to the provisional staff will take service call unless excused by the applicable department chair.

4.2.2 Courtesy Medical Staff. The courtesy staff shall consist of those practitioners eligible for medical staff membership who desire to attend patients in the Hospital, or otherwise wish to be affiliated with the Hospital, but who do not qualify for appointment in another category of the medical staff. Members of the courtesy staff who admit at least twenty-five (25) patients, provide consultations to at least twenty (20) patients or perform procedures on at least fifty (50) patients at the Hospital in a calendar year will be required to seek active staff membership. Members of the courtesy staff may be granted medical staff membership without being granted clinical privileges.

Members of the courtesy staff shall:

4.2.2.1 Be appointed to a specific department;

4.2.2.2 Not be required to attend departmental or medical staff meetings but shall be encouraged to do so;

4.2.2.3 Participate in emergency service on-call schedules, except that courtesy staff members that do not hold clinical privileges shall not be required to participate in emergency service on-call schedules, and seek consultations, as appropriate, in accordance with Section 4.1.1.4;

4.2.2.4 May be assigned additional duties by the head of their clinical department which may include assignments to a clinical service, or to serve on committees when appointed;

4.2.2.5 Not be eligible to vote at medical staff, department or committee meetings or hold medical staff office; and

4.2.2.6 Be subject to assessment of medical staff dues.

4.2.3 <u>Active Medical Staff</u>. The active medical staff shall consist of practitioners who regularly admit patients, consult, or perform procedures at the Hospital and who assume all the functions and responsibilities of membership on the active medical staff.

4.2.3.1 Members of the active medical staff shall:

1. Be appointed to a specific department or departments;

2. Serve on medical staff, departmental and Hospital committees as assigned by the President;

3. Be required to attend department, committee and medical staff meetings;

4. Demonstrate substantial and continuing commitment to the Hospital by participating in emergency service on-call schedules, providing consultation services in a manner established by the applicable department(s) (except as otherwise provided in Section 4.2.6), performing such officer, staff, committee, and department functions for which the practitioner is responsible by staff category, assignment, appointment, election or otherwise, and cooperating with and participating in the Hospital's malpractice prevention program, quality assessment and improvement program and peer review activities (whether relating to the practitioner or others);

5. Upon request of the Hospital or the medical staff, and in accordance with Hospital policy, provide necessary care within the scope of the practitioner's privileges to any patient seeking such treatment at the Hospital, regardless of such patient's ability to pay;

6. Be eligible to vote at medical staff, department or committee meetings and hold medical staff office;

7. To remain on Active Staff, practitioners are required to admit at least twenty-five (25) patients to the Hospital or provide consultations to at least twenty (20) patients at the Hospital or perform procedures on at least fifty (50) patients at the Hospital in a calendar year; and

8. Be subject to assessment of medical staff dues.

4.2.4 Consulting Medical Staff. The consulting medical staff shall consist of selected physicians and dentists who possess specialized knowledge and professional qualifications not readily available through the expertise of practitioners on the medical staff and who are willing to serve as consultants in a specialty field to members of the medical staff upon the invitation and recommendation of the Executive Committee and Board of Directors and appointment by the HA Board of Directors. Consulting medical staff members shall:

4.2.4.1 Be appointed to a specific department but shall not be eligible to admit patients to the Hospital;

4.2.4.2 Seek consultations, as appropriate, in accordance with Section 4.2.3.6.;

4.2.4.3 Not be required to serve on medical staff, departmental or Hospital Committees;

4.2.4.4 Not be required to attend departmental or medical staff meetings but shall be encouraged to do so;

4.2.4.5 Not participate in emergency service on-call schedules; and

4.2.4.6 Not be eligible to vote at medical staff meetings or hold medical staff office.

4.2.4.7 Not be subject to assessment of medical staff dues.

4.2.5 Adjunct Medical Staff

The adjunct staff shall consist of those practitioners who request and are eligible for membership on the medical staff, but do not want clinical privileges. In general, the rationale for such membership is related to the lack of patient volume, either at our hospitals or others, required to demonstrate proficiency for the privileges that would be requested. An example would include those physicians who choose to use the Hospitalist to admit and care for their inpatients.
Amended MS 9/13/11

Members of the adjunct staff shall:

Be appointed to a specific department;
Not be eligible for clinical privileges;
Have the quality of their work confirmed by two peer letters;

Not be eligible to admit patients;
Not be eligible to consult;
Not be eligible to vote at medical staff, department or committee meetings;
Not be eligible to hold medical staff office;
Be subject to assessment of medical staff dues
Be permitted to review the medical records of patients with whom the adjunct staff member has an ongoing treatment relationship for purposes of such ongoing treatment, unless such access is prohibited by applicable law.

4.2.6 Emeritus Medical Staff. Membership in this category shall be an honor bestowed on practitioners who have retired from the active medical staff of the Hospital and who are recommended by the credentials committee, Executive Committee and Board of Directors, and approved by the HA Board of Directors. Members of the emeritus staff are expected to retain an active interest in Hospital affairs but shall not be required to fulfill the qualifications for medical staff membership set forth in these bylaws. Members of the emeritus staff are not permitted to admit patients or otherwise render medical care at the Hospital. Active credentialing files will not be kept for Emeritus Medical Staff and they will not be subject to the reappointment process. Emeritus staff members may not vote or hold medical staff office.

4.2.7 Exemptions. Any member of the active medical staff who was appointed to the medical staff prior to January 1, 2010 and has fulfilled his or her service obligations may, at sixty-five (65) years of age, or at fifty-five (55) years of age and membership on the active medical staff for twenty (20) or more years, request exemption from the emergency service on-call, emergency consultation and committee service requirements of active medical staff membership. Dues obligations will remain the same as for all other active staff members. Requests for such exemptions must be in writing to the Executive Committee and must indicate the extent (in whole or in part) to which such individual intends to be exempt. Such notice shall be submitted on or before January 1 of the calendar year in which the member intends to exercise the exemption; provided, however, that if circumstances beyond the member's reasonable control make notice prior to January 1 impracticable, the member shall give notice as far in advance as possible. For purposes of this Section 4.2.6, any period(s) of time in which a member of the active medical staff is absent from the active medical staff due to illness, military service, advanced education, authorized leave of absence, or any other cause as may be determined by the Executive Committee from time to time, shall nevertheless count toward the twenty (20) year requirement described in the first sentence of this paragraph.

4.3 Appointment Process

4.3.1 Application Materials. All applications for appointment to the medical staff shall be in writing, signed and verified by the applicant, and submitted to Hospital Administration on a form prescribed by the Executive Committee with the approval of the Board of Directors. The applicant shall provide detailed information concerning his professional qualifications, as required by the application form and bylaws. The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. If such information is incorrect, incomplete or misrepresented, the applicant may be denied membership.

4.3.1.1 The applicant must provide verifiable information concerning his professional education and training. The applicant must provide documentation regarding

compliance with continuing medical education and training requirements as mandated by New York State law, including training in infection control practices, and as determined appropriate by Clinical Departments.

4.3.1.2 The applicant must describe his current professional licensure status and must submit a copy of his current license and registration.

4.3.1.3 The applicant must provide evidence of current professional liability insurance coverage in an amount no less than the defined level of malpractice insurance as prescribed by the Board of Directors and published in the rules and regulations of the medical staff. The applicant must agree in writing to disclosure of pertinent claim information to the Hospital by his present and former insurance carriers for purposes of credentialing.

4.3.1.4 The applicant must list and provide a summary of the allegations in any and all malpractice actions and professional disciplinary proceedings pending in New York or in any other state. With respect to closed malpractice actions and closed professional disciplinary proceedings, the applicant must disclose: the substance of the findings, if any; malpractice judgments and settlements, if any; and any findings of professional misconduct made by the professional disciplinary agency of this or any other state. With respect to all malpractice actions and professional disciplinary proceedings, both pending and closed, the applicant shall also disclose such other information, if any, as he deems appropriate.

4.3.1.5 The applicant must supply the names of all health care facilities with which the applicant has been associated or at which the applicant was employed or had privileges and the reasons for discontinuance of each such association, as applicable.

4.3.1.6 The applicant must state whether he has ever voluntarily or involuntarily relinquished any license, registration (including DEA registration), membership in any local, state or national professional society or board certification or eligibility in any jurisdiction or has had any such license, registration, membership or certification challenged. The applicant must also state whether any of his clinical privileges or medical staff appointments have ever been voluntarily or involuntarily revoked, suspended, limited, reduced, refused or not renewed at any other health care facility, and, finally, must describe any pending, existing or previous disciplinary actions against, or investigations about, him. The applicant must sign a waiver of confidentiality, to the extent required by Public Health Law Section 2805-k, with respect to information which the Hospital is required by law to obtain for purposes of its evaluation of the application.

4.3.1.7 The applicant must supply the names of at least three persons who can provide adequate references pertaining to the applicant's current professional competence, medical/clinical knowledge, technical and clinical skills, clinical judgment, ethical character, interpersonal skills, communication skills, and ability to work with others. All three references for practitioners must be professional peers. One of the references (at least) for Allied Health Professionals must be a professional peer. The applicant must authorize the Hospital to consult with appropriate representatives of the medical staffs of other health care facilities with which the applicant has been associated, as well as with qualified others whom the Hospital reasonably expects to have information pertinent to the applicant's clinical competence, character and ethical standards, to the extent that the Hospital reasonably requires such consultation in the

performance of its credentialing obligations under applicable law, regulation, and accreditation standards.

4.3.1.8 The applicant must provide verifiable information concerning the status and history of his mental and physical health and must agree to submit to a physical examination in accordance with the provisions of Section 405.3(b)(10) of Title 10 of the Codes, Rules and Regulations of the State of New York and the Joint Commission.

4.3.1.9 The applicant must set forth a specific request for a medical staff category, departmental assignment, and delineation of clinical privileges.

4.3.1.10 The applicant must state that he has received and will abide by the bylaws, rules, and regulations of the medical staff, and agrees to be bound by the terms thereof in all matters if granted membership or privileges of any type as set forth in Article V; and that the applicant agrees to be bound by the terms thereof in matters pertinent to consideration of his application, without regard to whether he is granted membership.

4.3.1.11 In accordance with Article XI of these bylaws, the applicant must sign a written release from liability of: (a) all representatives of the Hospital and its medical staff for their acts performed in good faith in connection with evaluating the applicant's credentials and (b) all individuals and organizations who provide information in good faith to the Hospital concerning the applicant's competence, ethics, character and other qualifications for appointment and clinical privileges, including otherwise privileged or confidential information.

4.3.1.12 Copies of all information and documentation obtained pursuant to Section 4.3.1 shall be placed in a file maintained by the Hospital exclusively for credentialing purposes. The Hospital shall safeguard the confidentiality of such material, in accordance with the Public Health Law Section 18.

4.3.2 Criteria for Appointment. Criteria for evaluating applications for appointment to the medical staff shall relate to: the applicant's licensure, relevant training and experience, current competence, character, areas of expertise, and physical and mental health status; ability to perform the privileges requested**,** patient welfare; the applicant's anticipated ability to fulfill the commitments of medical staff membership and the patient care objectives of the Hospital. To the extent that appointment decisions are based upon other than a practitioner's quality of care and/or professional competence, the Hospital will evaluate the impact that such decisions have on the quality of care, treatment and services at the Hospital.

4.3.3 Verification and Investigation. The application shall be submitted to the Medical Staff Coordinator who shall forward the application to the credentials committee. The Hospital shall seek to verify the information contained in the application and shall obtain the required National Practitioner Data Bank ("NPDB") report and all other documentation required by federal and state law. To the extent permitted by applicable law and accreditation standards, certain aspects of the primary source verification and credentialing process may be delegated; however, the Board of Directors shall retain the responsibility to make the final decision regarding the granting of medical staff membership and clinical privileges to all applicants.

4.3.3.1 The credentials committee shall notify the applicant promptly if an application is not complete. If the applicant does not complete the application within six (6) months of its submission to the Hospital, the applicant shall be notified in writing that the

application will be removed from consideration without prejudice to the applicant's right to submit a new application. When the information contained in the application has been verified and the credentials committee has collected all required materials and information the application shall be deemed complete.

4.3.3.2 Once the application is deemed complete, the credentials committee shall examine all compiled evidence of the character, professional competence, qualifications and ethical standards of the applicant and shall determine whether the applicant meets all of the necessary qualifications for the requested category of staff membership and clinical privileges. The applicant must appear for interviews if requested by Hospital Administration, the chair of the credentials committee and/or the department in which the applicant seeks clinical privileges. The chair of each department in which the applicant seeks clinical privileges shall provide the credentials committee with a written recommendation regarding the application, which shall include specific written recommendations for delineation of the practitioner's clinical privileges.

4.3.3.3 Within ninety (90) days after the application is deemed complete, the credentials committee shall make a written report of its investigation to the Executive Committee. This report shall include the completed application and all supporting documentation, the report of the department chair, and the credentials committee's recommendation, as follows: that the applicant be provisionally appointed to the medical staff (including recommended delineation of privileges); that his appointment be approved; that he be denied medical staff membership; that the staff category or clinical privileges be changed; or that the application be deferred for further consideration for a period not to exceed sixty (60) days, pending one or more stated conditions. Where the credentials committee recommends denial of appointment, deferral, or a change in staff category or clinical privileges, the reasons for such recommendation shall be stated, and such reasons must relate to the applicant's licensure, training and experience, current competence, character, physical and mental health status, ability to fulfill the commitments of medical staff membership, considerations of patient welfare, or the patient care objectives of the Hospital.

4.3.4 <u>Executive Committee Review</u>. At its next regular meeting after receipt of the report and recommendation of the credentials committee, the Executive Committee shall determine whether to recommend to the Board of Directors, or if expedited credentialing is used, to a subcommittee of the Board of Directors, that the practitioner be provisionally appointed to the medical staff, that medical staff membership be denied or that the application be deferred for further consideration. All recommendations for appointment must include a recommended delineation of clinical privileges, which may be qualified by probation, preceptorship or conditions. The recommendation of the Executive Committee, together with the application and all supporting documentation, shall be forwarded to Hospital Administration within thirty (30) days after the date of the Executive Committee meeting at which the application was considered.

4.3.4.1 When the Executive Committee recommends appointment to the medical staff, Hospital Administration shall promptly forward the application to the Board of Directors or if expedited credentialing is used, a subcommittee of the Board of Directors.

4.3.4.2 When the Executive Committee recommends denial of medical staff membership or recommends clinical privileges more restrictive than those requested, Hospital Administration shall within ten (10) days of the Executive Committee meeting so notify the applicant by certified mail, return receipt requested, and inform the applicant of the reasons for

such recommendation and his right to a hearing to the extent provided in Article X of these bylaws. Such adverse recommendation shall not be forwarded to the Board of Directors until the applicant has exercised or has been deemed to have waived his or her rights under Article X of these bylaws.

4.3.4.3 When the Executive Committee recommends deferring the application for further consideration, the application must be reconsidered within sixty (60) days. Upon reconsideration, the Executive Committee may not recommend further deferral.

4.3.5 **Expedited Credentialing**.

4.3.5.1 The Hospital may use an expedited review process for the granting or renewal of privileges provided there is a complete application that has received favorable recommendation from the Credentials Committee and the Executive Committee, in accordance with the process described above, and, unless otherwise determined by the Executive Committee, there is no evidence of any of the following with respect to the applicant:

1. a current challenge or a previously successful challenge to licensure or registration

2. an involuntary termination of medical staff membership at another organization

3. an involuntary limitation, reduction, denial, or loss of clinical privileges

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

4.3.5.2 The Medical Executive Committee recommendation(s) will be forwarded to a subcommittee of the Governing Body composed of the Medical Director and two members of the Governing Body appointed by the Chairman of the Governing Body (the "Expedited Review Committee"). The Expedited Review Committee may approve the application, recommend to the Governing Body that the application be denied in whole or in part or refer the application back to the Medical Executive Committee for further review. Any approval granted by the Expedited Review Committee shall be effective immediately and, the practitioner shall be notified by certified mail, return receipt requested within ten (10) days of the decision. Approved applicants shall be presented at the next scheduled meeting of the Governing Body. Any adverse recommendation made by the Expedited Credentialing Committee regarding an applicant is not considered to be effective until it is ratified by the Governing Body and the HA Board of Directors. A decision by the Expedited Review Committee to refer the application to the Medical Executive Committee shall require reconsideration of the application by the Medical Executive Committee at its next consecutive meeting, as appropriate.

4.3.6 **Governing Body**.

4.3.6.1 If the expedited credentialing process is not used, at its next regular meeting after receipt of a recommendation for appointment, the Governing Body shall act on the application and:

1. If the recommendation of the Governing Body is to grant appointment, Hospital administration shall within ten (10) day of the Governing Body's meeting so notify the applicant in writing and the chairs of the Executive Committee and of the appropriate department(s).

2. If the recommendation of the Governing Body is adverse to the applicant with respect to either appointment or delineation of clinical privileges, and the applicant has not waived or exhausted his fair hearing and appellate review rights, Hospital Administration shall within ten (10) days of the Governing Body's meeting so notify the applicant by certified mail, return receipt requested stating the reasons for the recommendation, and inform the applicant of his right to a hearing to the extent provided in Article X.

3. If the recommendation of the Governing Body is to defer the applicant, any such deferral shall state the reasons therefore, shall set a time limit within which such a subsequent recommendation to the Governing Body shall be made, and may include a directive that additional information be obtained to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation and new evidence in the matter, if any, the Governing Body shall make a recommendation either to provisionally appoint the practitioner to the medical staff or to reject the practitioner for medical staff membership.

4.4 Conditions and Duration of Appointment

4.4.1 Provisional Appointment. All initial appointments to the medical staff shall be provisional for up to a period of one (1) year, as determined by the Board of Directors upon its approval of the applicant's application. Reappointment may be provisional for up to two (2) additional one (1) year periods.

4.4.1.1 The failure to advance to non-provisional medical staff membership from provisional status within three (3) years of the initial date of hospital appointment, based on a failure to satisfy one of the proficiency standards set forth in Section 4.1.2, shall be deemed a termination of the practitioner's medical staff appointment. A practitioner whose provisional appointment is terminated shall have the hearing and appeal rights accorded under these bylaws to a member of the medical staff who has been denied reappointment.

4.4.1.2 A provisional medical staff member shall be assigned to a department, where his performance shall be observed by the chair of the department (or his designee) to determine his eligibility for non-provisional medical staff membership and, in accordance with the Hospital's policy on Focused Professional Practice Evaluation, to evaluate his ability to

perform the privileges granted. Advancement to non-provisional medical staff membership shall be determined based on the practitioner's qualifications to exercise the clinical privileges provisionally granted to the practitioner. The chair of the department to which the provisional staff member is assigned shall make a written recommendation on advancement at the end of the first or second year, as applicable, to the active staff, the courtesy staff, the consulting staff, or reappointment to the provisional medical staff on a form prescribed by the credentials committee.

4.4.2 Reappointment. Except as provided by the Board of Directors or the HA Board of Directors, initial reappointment shall be for a period of at least one (1) year and not more than two (2) years. Unless otherwise provided by the Board of Directors or the HA Board of Directors, each subsequent reappointment shall be for a period not greater than two (2) years; which means that no less than once every two years the credentials committee shall evaluate the credentials, physical and mental capacity and competence of each practitioner eligible for reappointment under these bylaws.

4.4.3 Practitioners Under Contract.

4.4.3.1 Practitioners having a contractual or employment relationship with the Hospital for either full-time or part-time service, whose duties are medical-administrative in nature or include clinical responsibilities or functions involving their professional capabilities as practitioners, must be members of the medical staff, in accordance with the appointment process set forth in these bylaws.

4.4.3.2 Termination, expiration or non-renewal of a contract or employment agreement between: (1) the Hospital and a practitioner, (2) the Hospital and any other entity, facility or organization pursuant to which the practitioner has been' granted privileges, or (3) a practitioner and an entity, facility or organization which has a contract or employment agreement with the Hospital shall result in automatic termination of the applicable Practitioner's medical staff membership and clinical privileges provided the practitioners privileges were solely and exclusively granted in conjunction with or growing out of such contract or employment agreement. In the case of such termination, expiration or non-renewal:

1. the Hospital and medical staff have no duty to provide notice, hearing, or review;

2. the applicable practitioner is deemed to have waived such notice, hearing or review; and

3. the Hospital and the members of the medical staff will be considered to be held harmless from any and all liability or loss incurred by the Practitioner as a result of such termination, expiration or non-renewal.

4.4.3.3 If a practitioner enjoys medical staff membership and Hospital privileges concurrently with, but independently of, privileges relating to a contract for the provision of clinical services with the Hospital, then upon the termination of such contract the privileges relating thereto shall automatically terminate without further action of the Hospital or its medical staff, but the privileges that were granted independently of such contract shall not so terminate.

4.4.3.4 A practitioner whose membership on the medical staff has been terminated or privileges reduced pursuant to Sections 4.4.3.2 and 4.4.3.3 shall not be entitled to the fair hearing rights contained in these bylaws and may reapply without prejudice.

4.4.4 Conditions of Appointment. Appointments to the medical staff shall confer on the appointee only such clinical privileges as have been delineated by the HA Board of Directors in accordance with these bylaws.

4.5 Reappointment

4.5.1 Request and Verification. Requests for reappointment to the medical staff must be submitted to Hospital Administration in writing on a prescribed form.

4.5.1.1 The applicant must supply the names of all health care facilities with which the applicant is or has been associated or at which the applicant as or was employed or had privileges since his last appointment and state whether his medical staff appointment, association, or practice status and/or clinical privileges in any other hospital or health care facility have ever been discontinued, revoked, suspended, limited, refused, reduced, terminated or not renewed either voluntarily or involuntarily since his last appointment. If any such association(s) or employment has been terminated, voluntarily or involuntarily, the applicant must also provide the reason for the discontinuance of each such association.

4.5.1.2 The applicant must state whether his membership in any local, state or national professional society board certification or eligibility, license to practice any profession in any jurisdiction, DEA registration, or any registration or license has ever been, or is currently, voluntarily or involuntarily challenged, suspended, restricted, revoked or terminated, and the reasons therefore.

4.5.1.3 The applicant must describe any disciplinary action taken and any pending disciplinary actions or investigations and the reasons for such action.

4.5.1.4 The applicant must verify that he is free of mental or physical health problems which might interfere with the performance of privileges requested. Issues may be addressed by either the chair of the department, the President, Medical Director, or the applicant's personal physician

4.5.1.5 The applicant must provide evidence of continuing medical education every two years as well as compliance with any other continuing medical education and training requirements mandated by New York State law or the applicable clinical department.

4.5.1.6 The applicant must supply any other documentation reasonably requested by the Hospital.

4.5.2 Department and Credentials Committee Review.

4.5.2.1 Hospital Administration shall forward the application to the credentials committee. The credentials committee, with the assistance of Hospital personnel, shall verify licensure and registration status and other information contained in the application, determine compliance with insurance requirements as specified in the rules and regulations, obtain reports from the NPDB, and review all other relevant information, including the practitioner's quality

file. The chair of each department in which the practitioner seeks clinical privileges shall forward to the credentials committee a specific recommendation as to the reappointment and delineation of clinical privileges. In the event that a department chair elects not to recommend reappointment, the department chair shall explain the basis for his decision in writing and shall forward such written explanation to the practitioner and the credentials committee.

4.5.2.2 Executive Review. The credentials committee shall transmit the completed application and supporting documentation, the report of the chair of each department in which the practitioner seeks clinical privileges, and a recommendation regarding reappointment to the Executive Committee. Thereafter, the procedure for reappointment shall be the same as the procedure specified for appointment in Section 4.3. In the event that the credentials committee elects not to reappoint a practitioner requesting reappointment, the credentials committee shall explain the basis for its decision in writing and shall forward such written explanation to the practitioner and the Executive Committee.

4.5.2.3 Criteria. Reappointment to the medical staff and delineation of clinical privileges upon reappointment shall be based upon the standards of the Joint Commission as well as New York State and Federal laws, and shall include consideration of: the member's professional competence; clinical judgment in the treatment of patients; physical and mental capacity to perform the essential functions of medical staff membership within the member's delineation of privileges, with or without accommodation; the member's ethics and conduct; quality assessment data (which shall include utilization data as appropriate); disposition of all malpractice claims; professional disciplinary actions; corrective actions; outcome of patient grievances; participation in continuing education; supervision of trainees and collaboration with allied health professional staff, if applicable; cooperation with other health care professionals; attendance at medical staff, committee, and department meetings; participation in medical staff activities; continuing commitment to the patient care mission of the Hospital; participation in emergency on-call and consultation services, unless the member is exempt from such participation; and compliance with Hospital bylaws and medical staff bylaws, rules and regulations.

4.6 Leave of Absence

4.6.1 Request for Leave. A member of the medical staff in good standing may obtain a voluntary leave of absence from the medical staff by submitting a written request to the President and President/Chief Executive Officer stating the anticipated period of the requested leave and the reason for the leave. The written request must be approved by the Executive Committee. If the leave is granted, none of the staff member's clinical privileges, membership prerogatives and membership obligations (including payment of medical staff dues) shall be exercisable for the duration of the leave.

4.6.2 Duration of Leave. Leaves of absence may be granted for a maximum of twelve months (12) months, except that the leaves of absence to fulfill military obligations may be granted for as long as necessary for the Medical Staff member to fulfill his or her military obligations. In the event that the practitioner does not return to active status, he shall be considered to have resigned from the medical staff, and shall be so informed by notice sent certified return receipt requested to the practitioner's last known address. Resignation from medical staff for failure to return from a leave of absence shall not entitle the practitioner to the fair hearing rights contained herein.

4.6.3 Return from Leave. At least sixty (60) days prior to the termination of the leave, the practitioner must notify the Hospital and the credentials committee of the practitioner's intent to resume his privileges by submitting a request in writing to the Medical Director. The practitioner must satisfy all of the applicable requirements of these bylaws. If the practitioner's reappointment date has lapsed during the leave, then he must complete the reappointment process before returning from the leave.

If a practitioner or allied health professional who is on a leave of absence comes up for reappointment, he must submit an application for reappointment and be approved for such reappointment in order to maintain his membership and/or clinical privileges. If a practitioner or allied health professional on a leave of absence cannot meet the qualifications for reappointment, he may resign and reapply for membership and/or clinical privileges, without prejudice.
Amended MS 9/13/11

4.7 Allied Health Professional Staff

4.7.1 Composition and Privileges. The allied health professional staff shall consist of health professionals, other than physicians, dentists or podiatrists, who are qualified by training and experience in disciplines determined by the medical staff and the Hospital to meet patient care needs and Hospital objectives; who are certified, registered and/or licensed to practice a health profession pursuant to the New York State Education Law or the New York Public Health Law; and who are authorized by the medical staff and the Hospital to exercise delineated clinical privileges.

4.7.1.1 Allied health professionals may include, without limitation, physicians' assistants, midwives licensed to practice in the State of New York, psychologists and nurse anesthetists. Each allied health professional shall be assigned to a specific department and shall participate in the management of patients and exercise judgment within his authorized scope of practice or individual delineation of privileges. However, a member of the allied health professional staff shall not be a member of the medical staff, and may only render services and participate in patient management subject to supervision, direction, or collaboration provided by a qualified member of the active medical staff, in accordance with applicable law, who has full responsibility for the patient's overall care and medical management.

4.7.1.2 Allied health professionals may not admit patients to the Hospital and may not vote or hold medical staff office. They may be required to attend medical staff or departmental meetings at the discretion of the President or department chair, respectively.

4.7.1.2 (a) Allied health professionals also include Nurse Practitioners and Licensed Midwives, who may function independently in accordance with New York State Regulations. Nurse Practitioners do not need a collaborative agreement with a qualified physician. Midwives need to have a *collaborative relationship* with a qualified physician. Nurse Practitioners and Licensed Midwives may admit patients to the hospital but may not vote or hold medical staff office. Malpractice Insurance requirements are $1/$3 million. ***Amended MS 3/28/13 for NPs and 5/15 for LM.***

4.7.1.3 Where applicable laws, regulations, or Hospital policies require that medical record entries made by a member of the allied health professional staff be counter-

signed by a supervising or collaborating physician, the medical record must be co-signed by the practitioner providing supervision, direction, or collaboration to such allied health professional.

4.7.1.4 Allied health professionals shall be subject to assessment of staff dues.

4.7.1.5 Allied health professionals may be assigned to a clinical service by the Chairman of their respective department.

4.7.2 Appointment and Reappointment. The procedures for appointment and reappointment shall be the same as those for the medical staff as specified in this Article IV, adapted as appropriate for allied health professional staff applications. Each allied health professional shall be certified in his field of practice or qualified to be a candidate for such certification as specified in the rules and regulations of the medical staff. The recognized accrediting body for allied health professionals will be defined in the rules and regulations of the medical staff. Applications shall include a request for specific clinical privileges and shall be evaluated generally in accordance with the procedures for medical staff appointment and reappointment. Any ambiguity concerning the applicability of particular bylaw provisions regarding applications for appointment and reappointment of allied health professionals shall be resolved by the credentials committee and Executive Committee, subject to final determination by the HA Board of Directors.

4.7.2.1 The application shall include a statement from the medical staff member who will provide supervision, direction or collaboration for the applicant (collectively referred to in this section as the "supervising medical staff member"). Such statement shall specify the clinical privileges which the supervising medical staff member considers the applicant qualified to exercise. The statement shall also indicate the medical staff member's willingness to supervise the applicant, collaborate with or direct, the applicant and to assure assure that the activities conducted by such applicant are subject to and satisfy the quality of care and utilization review procedures and standards of the Hospital and are carried out in a manner consistent with applicable licensing laws of the State of New York. A medical staff member may not supervise an allied health professional in the exercise of clinical privileges which the supervising medical staff member is not himself authorized to exercise.

4.7.2.2 Criteria for evaluation of allied health professional applicants shall be established uniformly for each category of allied health professional. Each department, in consultation with the credentials committee and other appropriate sources of information, and subject to the approval of the Executive Committee and Board of Directors, shall be responsible for developing departmental standards and basic qualifications for allied health professionals. Such standards shall relate, at a minimum, to the licensure, relevant training and experience, current competence, areas of expertise, character, ethics, and physical and mental health status of such applicants. Evaluation of an allied health professional applicant shall be based upon the individual training, experience and demonstrated competency of each individual, taking into consideration the permissible scope of services rendered by the particular profession of the allied health professional. Consideration shall also be given to the Hospital's ability to provide the practitioner with adequate facilities and support services in connection with the requested privileges, and to patient care needs for practitioners with the applicant's skill and training.

4.7.2.3 All initial appointments of allied health professionals shall be provisional for up to a period of one (1) year. Reappointment may be provisional for one (1)

additional year, except that allied health professionals who have not yet received certification in their field but who remain eligible to receive such certification within the time limits set forth in the rules and regulations may continue their provisional status up until the applicable time limit set forth in the rules and regulations.

4.7.2.4 Any allied health professional with provisional privileges seeking to advance to non-provisional status shall be requested to present evidence that he is certified, registered or licensed, as applicable. The failure to advance to non-provisional status following two years of provisional membership, unless such provisional membership is extended while the practitioner seeks certification, shall be deemed a termination of appointment. An allied health professional whose provisional appointment is terminated other than for lack of certification shall have the hearing and appeal rights accorded under these bylaws to a practitioner who has been denied reappointment. An allied health professional whose appointment is terminated for lack of certification shall not have hearing or appeal rights under these bylaws. All appointments shall be for a period not to exceed two (2) years.

4.7.3 Practitioner Utilization of Allied Health Professionals. Each practitioner wishing to utilize the services of an allied health professional must be a member of the active medical staff, as described in Section 4.2.4, and be credentialed to perform the procedures for which the allied health professional's services will be utilized. Practitioners may supervise, or collaborate with, the number of allied health professionals permitted under applicable law.

4.8 Organ Procurement Organization Representatives. Health care professionals acting on behalf of an organ procurement organization designated by the United States Department of Health and Human Services, whose activities at the Hospital consist solely of harvesting tissues and organs for transplantation, therapy, research, or educational purposes pursuant to the Anatomical Gift Act, shall not be required to apply for medical staff privileges in order to engage in such activities, but shall be required to comply with all applicable provisions of Hospital policies and medical staff rules and regulations.

4.9 Voluntary or Involuntary Termination of Medical Staff Membership. The medical staff member should notify Hospital Administration, in writing, of any voluntary or involuntary termination of medical staff membership, licensure or registration or any alteration or changes in privileges, voluntary or involuntary, at any other health care facility. Hospital Administration shall forward this notification to the credentials committee. The credentials committee will investigate the reasons and will forward their recommendation to the Executive Committee. It is understood that if voluntary termination of medical staff membership was or appears intended by the medical staff member to avoid investigations or proceedings, the credentials committee will investigate the circumstances. After reviewing the case, a determination regarding the validity of the voluntary termination of membership will be made and a recommendation will be forwarded to the Executive Committee.

ARTICLE V

CLINICAL PRIVILEGES

5.1 Delineation of Clinical Privileges

Every practitioner practicing in the Hospital shall be entitled to exercise only those clinical privileges specifically granted to him by the Board of Directors, except as otherwise provided in these bylaws. Every initial application for medical staff appointment or allied health professional staff appointment, and every application for reappointment, must contain a request for specific clinical privileges, except that members of the courtesy staff may be granted medical staff membership without being granted clinical privileges. Evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references, and other relevant information, including a review of the NPDB each time new privileges are requested and an appraisal by the chair of the clinical department in which privileges are sought. The Hospital and medical staff will also take into consideration the availability of resources (e.g., space, equipment, staffing, financial resources) necessary to support the requested privileges.

The applicant shall have the burden of establishing his qualifications and competency in the clinical privileges he requests. In the event that a medical staff member seeking reappointment has inadequate activity at the Hospital to establish competency to perform the privileges requested, the medical staff member may: (a) demonstrate competency by at least three (3) letters of recommendation from physicians who have worked with the applicable medical staff member within the last two years and are familiar with his competency to perform the requested privileges; (b) request to be changed to adjunct staff status without clinical privileges or (c) request that the applicable privileges be withdrawn. Unless otherwise stated herein or required by law, a request to withdraw privileges as a result of inactivity does not give rise to a reporting obligation to New York State or the NPDB.

5.1.1 Dental Privileges. All dental patients shall receive from a physician member of the medical staff the same basic medical appraisal as patients admitted to other surgical services, and a physician member of the medical staff shall be responsible for the care of any medical problem that may present at the time of admission or that may arise during hospitalization.

5.1.2 Podiatric Privileges. All podiatric patients shall receive from a physician member of the medical staff the same basic medical appraisal as patients admitted to other surgical services, and a physician member of the medical staff shall be responsible for the care of any medical problem that may present at the time of admission or that may arise during hospitalization.

5.1.3 Allied Health Professionals Privileges. Qualified allied health professionals will be assigned to appropriate clinical departments by the Board of Directors on a recommendation of the Executive Committee. The appropriate clinical department shall establish written policies and procedures to govern the activity of any allied health professionals assigned to their department consistent with these bylaws.

5.1.4 Resident Physicians and Medical Student Privileges. Resident physicians and medical students are the responsibility of the individual department and specifically, of the supervising attending physician. The attending physician has the legal responsibility to provide

appropriate supervision to such residents and medical students. Each department shall grant privileges to the residents based upon their level of training, the limitations and requirements provided in the medical staff policy regarding supervision of graduate medical education participants and the requirements of the ACGME and applicable law. Medical Students shall only be authorized to perform those services expressly permitted in the medical staff policy regarding graduate medical education.

5.1.5 Privileges to Perform a History and Physical. A medical history and physical examination ("H&P") must be completed on each patient within 7 days before or 24 hours after each inpatient admission. If the H&P is performed prior to admission, it must be updated within 24 hours of admission or prior to any surgical procedure. Privileges to perform H&Ps may be granted to any appropriately trained and privileged physician, oral maxillofacial surgeon or licensed practitioner to the extent permitted by New York State law and Medical Staff policy. The medical staff shall adopt policies regarding the content of H&Ps and the requirements for H&Ps prior to outpatient procedures.

5.1.6 Emergency Privileges. In an emergency, any practitioner who is a member of the medical staff and who has privileges shall be permitted, to the extent consistent with his licensed scope of practice, to provide any patient care necessary as a life-saving measure or to prevent serious patient harm, using every necessary facility and service of the Hospital, including any assistance or consultation. When an emergency situation no longer exists, appropriate consultation shall be sought and the patient shall be assigned to an appropriate member of the medical staff. For the purpose of this Section 5.1.6, an "emergency" is defined as a situation in which the life of a patient is in immediate danger and in which any delay in administering treatment would unreasonably increase that danger. Nothing in this Section 5.1.6 shall be deemed to impose upon any practitioner a duty to treat a particular patient, if the practitioner does not otherwise have a professional duty to such patient.

5.1.7 Voluntary or Involuntary Termination or Reduction of Clinical Privileges. The medical staff member should notify Hospital Administration, in writing, of any voluntary or involuntary termination or reduction of clinical privileges at this hospital or any other health care facility. Hospital Administration shall forward this notification to the credentials committee. The credentials committee will investigate the reasons and will forward their recommendation to the Executive Committee. It is understood that if voluntary or involuntary termination or reduction of clinical privileges, voluntary or involuntary, at this Hospital or any other institution, was or appears intended by the medical staff member to avoid investigations or proceedings, the credentials committee will investigate the circumstances. After reviewing the case, a determination will be made regarding the validity of the voluntary or involuntary termination or reduction of privileges, and a recommendation will be made to the Executive Committee.

5.2 Temporary Privileges

5.2.1 General

5.2.1.1 Practitioners with temporary privileges shall act under the supervision of the chair of the department to which they are assigned.

5.2.1.2 Temporary privileges are granted for no more than 120 days and shall be granted only in situations where acceptable circumstances exist.

5.2.2 New Applicants

5.2.2.1 Temporary privileges for new applicants may be granted while they are awaiting review and action by the Executive Committee and the Board of Directors after they have been approved by the credentials committee and upon receipt and acceptability of the following:

a. A complete application, including applicable fees and evidence of current licensure, relevant training and experience, current competence and ability to perform the privileges requested.

b. Verification of information provided in the application in accordance with the appointment process described in these bylaws.

c. Verification of medical malpractice insurance as required for Medical Staff membership

d. A query of the NPDB

e. Verification that no current or previously successful challenge to licensure or registration

f. Verification that the applicant has not been subject to involuntary termination of medical staff membership at another organization

g. Verification that the applicant has not been subject to involuntary limitation, reduction, denial or loss of clinical privileges

In the event that any of these criteria are not met, the applicant will be required to go through the full privileging process before being granted privileges.

5.2.2.2 Temporary privileges shall automatically terminate, without further action of the medical staff or Board of Directors, should the Executive Committee not recommend or the Board of Directors not grant privileges in the regular application process. Temporary privileges may be terminated immediately, if reasonably necessary in the best interest of patient care, by any person authorized to impose a summary suspension under these bylaws. In the event of such immediate termination, the appropriate department chair/vice chair or, in his absence, the President shall assign a member of the medical staff to assume responsibility for the care of the patient(s) of the practitioner whose privileges were terminated. A practitioner shall have no hearing or appeal rights under these bylaws based solely upon termination of temporary privileges.

5.2.3 Patient Care, Treatment and Service Need. Temporary privileges may also be granted to fulfill a patient care, treatment, and service need.

5.2.3.1 Temporary privileges may be granted to meet an important patient care need for a specific patient upon receipt of a written request from a member of the medical staff requesting permission for a practitioner who is not a member of the medical staff to assist in care of a patient. The request must include patient's name, date of procedure, procedure name, name of the practitioner who is requesting temporary privileges and his/her Curriculum Vitae. These

temporary privileges may be granted to a practitioner for treatment of a specific patient upon receipt and acceptability of the following:

a. New York State license and current registration which shall be verified by the Medical Staff Office

b. Current certificate of malpractice insurance with limits as required by these medical staff bylaws

c. Current delineation of privileges from primary hospital/facility

d. Written confirmation from a Medical Staff member regarding the relevant physician's competence to perform the privileges requested

e. A query of the NPDB

Such temporary privileges shall automatically terminate when the specific patient is discharged.

5.2.3.2 Temporary privileges may be granted to address short-term service needs (e.g., a physician working on a locum tenens basis). Privileges granted to meet a short term service need Verification of applicant identity

f. Completed application

g. Current physical examination form (including Mantoux test result)

h. Current certificate of malpractice insurance with limits as required by these medical staff bylaws

i. One reference letter or a background check by the locums agency.

j. New York State license and current registration which shall be verified by the Medical Staff Office

k. Copy of current DEA certificate (as applicable)

l. Proof of board certification (if applicable)

i. A query of the NPDB, OMIG, OIG, OPMC and the AMA (if applicable)

j. Department of Health and/or The Joint Commission required vaccines.

5.2.3.2 may be granted based upon receipt and acceptability of the following:

As soon as reasonably possible, the applicant for temporary privileges to meet a short term service need shall be presented to the credentials committee and Board of Directors for approval. Temporary privileges for a service need shall terminate within the time frame set by the Board of Directors which shall not exceed 120 days. Under no circumstances shall a Practitioner granted temporary privileges for a service need have a right to a hearing or appeal under these bylaws.

5.3 Disaster Privileges

Disaster privileges may be granted by the President/Chief Executive Officer or his designee to a practitioner for up to seventy-two hours if the Hospital's emergency management plan has been activated, and there is a determination by the President/Chief Executive Officer or his designee that existing resources are insufficient to provide all required care. Such privileges shall be granted on a case by case basis; there shall be no requirement to grant disaster privileges to any practitioner.

5.3.1 Evidence of Qualifications. Disaster privileges may be granted upon presentation of a valid government-issues photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

5.3.1.1 A current picture hospital ID card that clearly identifies professional designation,

5.3.1.2 A current license to practice,

5.3.1.3 Primary source verification of the license,

5.3.1.4 Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals Program (ESAR-VHP) or other recognized state or federal organizations or groups,

5.3.1.5 Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity), or

5.3.1.6 Identification by current Hospital or Medical Staff member(s) who possess personal knowledge regarding a volunteer Licensed Independent Practitioner's ability to act as Licensed Independent Practitioner during a disaster.

5.3.2 Supervision. If possible, the volunteer Practitioner shall be paired with a member of the Medical Staff in the same specialty to act as the mentor of the volunteer Licensed Independent Practitioner. If circumstances do not allow for a mentor or direct observation, the clinical notes made by the Practitioner with disaster privileges will be immediately reviewed by a member of the Medical Staff with appropriate privileges when the disaster has ended. In all events, the Medical Staff is responsible for overseeing the professional practice of volunteer Practitioners.

5.3.3 Miscellaneous. Volunteer Practitioners will be issued an ID badge which clearly states their volunteer status and whenever possible, the Medical Staff or Administration Office will maintain a roster of all volunteer Practitioners and the cases in which they are involved.

5.3.4 Primary Source Verification. Unless there are extraordinary circumstances (e.g., no means of communication), primary source verification of licensure shall begin as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer Practitioner presents to the Hospital. In extraordinary circumstances in which the verification cannot be completed within 72 hours, there must be documentation of the following:

5.3.4.1 why primary source verification could not be performed in the required time frame;

5.3.4.2 evidence of demonstrated ability to continue to provide adequate care, treatment and services; and

5.3.4.3 an attempt to rectify the situation as soon as possible.

5.3.5 Extension of Privileges. If the disaster still exists 72 hours after the initial disaster privileges were granted, the Chief Executive Officer or his designee may extend a Practitioner disaster privileges for another 72 hours. Such extension will be based upon the information obtained and documented pursuant to Section 7.7.5.

ARTICLE VI

CLINICAL DEPARTMENTS

6.1 Organization of Clinical Departments

The medical staff shall be organized into separate clinical departments, each with a chair who shall be responsible for the overall supervision of patient care within the department. The departments shall be those set forth below:

Anesthesiology
Family Medicine
Internal Medicine
Neurosciences
Obstetrics & Gynecology
Pathology
Pediatrics
Psychiatry
Radiology
Surgery

6.2 Assignment to Departments. The Executive Committee shall, after consideration of department recommendations and the training, experience and practice area of the practitioner, recommend to the Board of Directors an initial department for each practitioner with clinical privileges. The practitioner shall be subject to the rules, regulations and policies of the department.

Certain practitioners may be granted clinical privileges in more than one department, consistent with their education, training, experience and demonstrated competence subject to the provisions of Article IV of these bylaws. Such a practitioner shall be subject to all the criteria and policies of each department of which he is a member and to the jurisdiction of each department chair. Each such practitioner shall be assigned to one primary department for the purpose of participating in the functions described in this Article VI and fulfilling all other obligations of medical staff membership.

6.2.1 Establishment of Departments. Departments may be added to or removed from the medical staff by adoption of amendments to these bylaws, in accordance with Section 11.3, upon a recommendation by the Executive Committee that such addition or removal is in the best interests of the quality of patient care.

6.3 Department Functions

6.3.1 Policies. Each department shall establish rules, regulations and policies, consistent with the rules, regulations and policies of the medical staff and the Board of Directors, for carrying out the functions of the department.

6.3.2 Meetings. Each department shall conduct at least four (4) meetings per year. Each department shall (a) recommend its own criteria for the granting of clinical privileges to be approved by the Executive Committee and (b) monitor and evaluate medical care in all major clinical activities of the department including the routine collection of information about important aspects of patient care provided in the department and about the clinical performance of its members and the periodic assessment of this information to identify opportunities to improve care and to identify problems in patient care.

6.4 Department Chairs and Vice-Chairs

Each department shall have a chair and vice-chair, each of whom shall be a member in good standing of the active medical staff who is assigned to that department. Each chair and vice-chair shall be recognized for current competence in his field and shall have demonstrated a high level of interest and support of the medical staff and of the Hospital. Each chair and vice-chair must be certified by an appropriate specialty board, or affirmatively establish comparable competence through the credentialing process. For departments that are staffed by contract groups, the department chair may be selected from the contract group with the approval of Hospital Administration and the Board of Directors. Even though such department chair may be on provisional status, he or she shall have the same voting privileges as active medical staff members.

6.4.1 Election of Chairs and Vice-Chairs. Each department shall elect a chair and vice-chair by a majority vote of the active medical staff members, subject to approval of the Board of Directors. Such vote shall be taken by ballot sent or faxed to the Medical Staff Office. In order to determine the majority, a deadline will be indicated on the ballots when they are sent out. A majority vote shall be determined by counting those ballots received by such deadline. In the case of a deadlocked, tie vote in any department, the Executive Committee shall cast the deciding vote. For departments that are staffed by contract groups, the department chair may be recommended by a vote of the Medical Staff members of the contract group, even though such Medical Staff members are on provisional status and do not otherwise have voting privileges.

6.4.2 Responsibilities of Department Chair. Each department chair shall be certified by an appropriate specialty board and be responsible for all professional and administrative activities within the department as follow:

6.4.2.1 Clinically related activities of the department.

6.4.2.2 Responsible for the enforcement of the Hospital bylaws, the medical staff bylaws and the rules and regulations within the department.

6.4.2.3 Responsible for the creation and annual review of department rules and regulations

6.4.2.4 Responsible for development, in consultation with the Medical Director, of an emergency room on call coverage schedule and for the provision of consultation services by members of the department.

6.4.2.5 Dissemination and implementation within the department of all actions taken by the Executive Committee.

6.4.2.6 Make recommendations to the Executive Committee concerning medical staff appointment and reappointment, department assignments, and delineation of clinical privileges.

6.4.2.7 Cooperate with the nursing service and Hospital Administration in matters affecting patient care within the department, including personnel, supplies, special procedures, standing orders and techniques

6.4.2.8 Assist in the preparation of such reports, including department budgets, as may be requested by the Executive Committee or Hospital Administration.

6.4.2.9 Administratively related activities of the department, unless otherwise provided by the hospital.

6.4.2.10 Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.

6.4.2.11 Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department.

6.4.2.12 Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization.

6.4.2.13 The integration of the department or service into the primary functions of the organization

6.4.2.14 The coordination and integration of interdepartmental and intradepartmental services.

6.4.2.15 The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

6.4.2.16 The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.

6.4.2.17 The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

6.4.2.18 The continuous assessment and improvement of the quality of care, treatment, and services.

6.4.2.19 The maintenance of quality control programs, as appropriate.

6.4.2.20 The orientation and continuing education of all persons in the department or service.

6.4.2.21 Recommending space and other resources needed by the department or service.

6.4.2.22 Enforcement of laws established by all regulatory agencies.

6.4.3 Responsibilities of Department Vice-Chair. Each department vice-chair shall preside with vote at all meetings of the Executive Committee in the absence of the chair, and shall perform such duties as may be required by the chair or the Executive Committee. When the chair and vice-chair of a department are present at a meeting of the Executive Committee, only the chair of such department shall be entitled to vote.

6.4.4. Tenure of Department Chairs and Vice-Chairs. The Chairs and Vice-Chairs of each department will serve for a two year term. At the end of that term, the medical staff office will notify the department that they are accepting nominations. Those nominations will be sent out prior to the election meeting. If there are no nominations, the current chair and vice-chair will remain in office for another two years.

The term of each chair's and vice-chair's office shall begin immediately following their election. Each chair and vice-chair shall serve until a successor is elected or appointed (in the case of contracted groups) or unless he/she sooner dies, resigns or is removed from office.

6.4.5. Removal from Office. A Chairman or Vice Chairman, during his term of office, upon failure to perform the duties as described in these bylaws or upon failure to adhere to the requirements of these bylaws, may be removed by a vote of two-thirds (2/3) of the active medical staff members of the department, subject to the approval of the Board of Directors in consultation with the Executive Committee.

6.5 Department Meetings

Each department shall hold regular meetings as set forth in Section 6.3.2. A special meeting of a department may be called at any time by the department chair. A special meeting may also be called at the request of the President or of one-third of the voting department members (but not less than two (2) members).

6.5.1 Notice. Written notice of the date, time and place of any special or regular meeting shall be given to each department member not less than seven (7) calendar days in advance of such meeting by the person or persons calling the meeting. If mailed, the notice shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to the department member at his address as it appears in the records of the Hospital. The attendance of a department member at a regular or special meeting shall constitute a waiver of notice of such meeting.

6.5.2 Quorum and Action. Twenty-five percent (25%) of the voting members of the department, but not less than two (2) members, shall constitute a quorum at any regular or special meeting. Except as otherwise provided in these bylaws or pursuant to law, the vote of a majority of the voting members of the department present at a regular or special meeting at which a quorum exists shall be the action of the department.

6.5.3 Minutes. Minutes of each regular and special meeting of a department shall be prepared and shall include a record of the attendance of department members and of all votes taken on any matter. The minutes shall be prepared and maintained for departmental meetings and matters pertaining to medical peer review functions. The minutes shall be signed by the department chair and maintained in a permanent file of the Medical Staff Services Office, which shall be available to department members upon request. The minutes of each department meeting shall be promptly submitted to the Executive Committee. The confidentiality of minutes of matters pertaining to medical peer review functions shall be safeguarded.

6.5.4 Attendance Requirement.. Each member of the active medical staff shall be encouraged to attend not less than one-quarter (1/4) of all meetings in each year of each department of which he is a member in each year. Failure to meet the attendance requirement, unless excused by the department chair for good cause, shall be considered during reappointment. Such failure shall be considered in evaluation of the member's application for reappointment, and may be grounds for corrective action pursuant to Article IX of these bylaws.

ARTICLE VII

ADMINISTRATION OF THE MEDICAL STAFF

7.1 Officers of the Medical Staff

Subject to the provisions of Section 7.2.1, the officers of the medical staff shall be a President, a Vice President, a Secretary and a Treasurer. Each officer must be a member of the active medical staff at the time of election to medical staff office and must remain a member in good standing during his term of office. If an officer ceases to be a member in good standing of the active medical staff, he shall be automatically removed from office.

7.1.1 President. The President shall serve as the chief administrative officer of the medical staff. The President shall act in coordination with Hospital Administration in all matters of mutual concern. The President and President/Chief Executive Officer shall serve as liaisons between the medical staff and the Board of Directors, presenting the views, policies, needs, grievances and recommendations of the medical staff to the Board of Directors, and presenting the policies and decisions of the Board of Directors to the medical staff.

The President shall call, set the agenda, and preside at all meetings of the medical staff; serve *ex officio* as a voting member of the Executive Committee; serve *ex officio* as a member of all other medical staff committees without vote; and appoint special committees; and serve *ex officio* as a member of the Board of Directors. The President shall be responsible for the initiation of the enforcement of the bylaws, rules and regulations of the medical staff, for implementation of sanctions where indicated, and for compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner. The President shall be the spokesperson for the medical staff in its external professional and public relations.

7.1.2 Vice President. In the absence of the President of the medical staff, the Vice President shall assume the duties and have the authority of the President. The Vice President shall serve *ex officio* as a voting member of the Executive Committee and serve *ex officio* as a member of the Board of Directors. The Vice President shall be the president-elect of the medical staff and shall automatically succeed the President when the latter ceases to serve for any reason.

Such remaining term shall not be considered as a consecutive term in the rules of two consecutive terms noted in Section 7.2.4. The Vice President shall serve on the Quality Council.

7.1.3 Secretary. The Secretary shall serve *ex officio* as a voting member of the Executive Committee. The Secretary shall give notice of medical staff meetings, keep accurate and complete minutes of medical staff meetings and Executive Committee meetings, attend to medical staff correspondence, and perform such other duties as ordinarily pertain to such office. ***Amended MS 1/10/12***

7.1.4 **Treasurer.** The Treasurer shall serve *ex officio* as a voting member of the Executive Committee. The Treasurer shall attend to the medical staff finances, collect medical staff dues, and perform such other duties as ordinarily pertain to such office. ***Amended MS 1/10/12***

7.2 Election and Term of Office

7.2.1 Nomination. Officers shall be nominated for election by the means set forth in this Section 7.2.1. Nominations shall be closed thirty (30) days prior to the date of the annual meeting (the "Closed Period").

7.2.1.1 Election of the Nominating Committee. The Nominating Committee shall be elected every two years and shall consist of no less than three (3) and no more than five (5) members of the active medical staff. Departments will be allowed only one representative on the committee. The members of the outgoing nominating committee will recommend the members for the next committee. However, any member of the Active Medical Staff may submit their names to the Medical Staff Office if they would like to serve on this committee. Those names will be given to the current nominating committee and presented to the medical staff at the first spring meeting of the medical staff. The nominating committee will then be elected at that meeting.

7.2.1.2 Responsibilities of the Nominating Committee It is the responsibility of the Nominating Committee to present to the medical staff, candidates who would like to be considered for a medical staff office. These candidates will be presented at the first medical staff meeting held in the fall, and the nominating committee shall offer one (1) nominee for each office. If the nominating committee has no candidates for office, the current medical staff officers will continue to serve.

7.2.1.3 Nominations Officers shall be nominated for election by the means set forth in this Section 7.2. Nominations shall be closed thirty (30) days prior to the date of the first meeting of the New Year, and the staff will be notified of the nominees.

7.2.1.4 Nominating by Petition Nominations may be made by voting members of the medical staff by submitting such nomination(s) in writing, and signed by at least ten (10) active medical staff members to the Secretary or designee during the time immediately preceding a Closed Period (30 days prior to the annual meeting).

7.2.1.5 Election. Officers shall be elected at the first meeting of the New Year (the annual meeting) pursuant to the quorum and voting requirements of Section 7.3.5. Only members of the active medical staff shall be eligible to vote. ***Amended MS 1/10/1.***

7.2.2 Term of Office. Each officer shall serve for a term of two (2) years and may be subsequently re-elected. Each officer shall serve until a successor is elected or until he sooner dies, resigns, or is removed. Vacancies in office, except for the presidency, shall be filled by the Executive Committee. If there is a vacancy in the office of the President, the Vice President shall serve out the remaining term of the President whose office has become vacant. Officers shall take office on the first day after the election.

7.2.3 Resignation and Removal. An officer may resign at any time by giving written notice to the President or the Secretary. Any officer may be removed with cause by a majority vote of the voting members of the medical staff, or without cause by a two-thirds (2/3) vote of the voting members of the medical staff. Grounds for removal of an officer with cause include, but are not limited to (i) failure to perform the duties of the position held in a timely and appropriate manner or (ii) failure to satisfy continuously the qualifications for the position. No such removal shall be effective unless it has been ratified by the Board of Directors, with proper notification of the individual concerned. Removal as an officer does not entitle the Medical Staff members to the due process rights contained herein.

7.3 Medical Staff Meetings

7.3.1 Annual Meeting. An annual meeting of the medical staff shall be held in the first quarter of each year. Retiring officers and committee chairs shall make such reports as may be desirable, and officers for the ensuing year shall be elected. The Board of Directors shall be invited to attend.

7.3.2 Regular Meetings. In addition to the annual meeting, there shall be at least three regular meetings of the medical staff per year.

7.3.3 Special Meetings. The President may call a special meeting of the medical staff at any time. The President also shall call a special meeting within seven (7) days after receiving a written request signed by at least ten percent (10%) of the voting medical staff and stating the purpose of the requested special meeting. The date set for the special meeting shall not be more than thirty (30) days from the date on which the President received the request for the meeting.

7.3.4 Notice. Notice shall be given of all annual, regular and special meetings of the medical staff. Notice of all meetings shall be posted in a conspicuous place in the Hospital. If mailed, notice of a meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each member at his address as it appears on the records of the Hospital. The attendance of a member of the medical staff at an annual, regular or special meeting shall constitute a waiver of notice of such meeting.

7.3.4.1 Notice of Annual and Regular Meetings. Notice of the annual and regular meetings stating time, place and date of the meeting shall be mailed to each medical staff member or left in staff mail boxes at least three (3) weeks in advance of the meeting.

7.3.4.2 Notice of Special Meetings. Notice stating the date, time and place of a special meeting and the business to be conducted shall be delivered, either personally or by mail or staff mail boxes, to each member of the medical staff at least seven (7) days but not more than thirty (30) days in advance of the meeting; provided that any notice of a special meeting to amend the bylaws shall be given at least fourteen (14) days in advance of the meeting. No business shall be conducted at any special meeting except that stated in the notice

7.3.5 Quorum and Action. The physical presence of at least thirty (30) members of the voting medical staff at any annual, regular or special meeting shall constitute a quorum. Once a quorum is established, a simple majority of the number of votes received either remotely (i.e., from a medical staff member participating by other telecommunication methodology) or in person, during an annual, regular or special meeting shall be considered the action of the medical staff, except that different requirements, described in Section 11.3, shall apply to voting on amendments to the bylaws, rules and regulations. ***Quorum Amended MS 3/28/13***

7.3.6 Minutes. Minutes of each annual, regular and special meeting of the medical staff shall be prepared and shall include a record of attendance and of all votes taken on any matter. The minutes shall be signed by the Secretary, and maintained in a permanent file of the medical staff, which shall be available to medical staff members upon request.

7.3.5 Dues. There will be annual membership dues, with fees to be set annually by the Executive Committee. Members shall be required to pay dues upon demand of the Treasurer. Failure to pay dues may be grounds for corrective action pursuant to Article IX of these bylaws.

ARTICLE VIII

COMMITTEES

8.1 Committees of the Medical Staff

8.1.1 Standing Committees. The standing committees of the medical staff shall consist of an Executive Committee, bylaws committee, credentials committee, nominating committee (as described in Section 7.2.1.1), quality council, Pharmacy, Nutrition and Therapeutics, and such other committees as ***determined by the Executive Committee.** The President and the Medical Director shall serve as *ex officio* members, without vote, of each standing committee, unless otherwise provided herein. Each standing committee shall report to the Executive Committee in writing after each meeting. ***PNT Entered 3/28/13***

8.1.2 Special Committees. The President, in consultation with the Medical Director, may appoint a special committee of the medical staff and assign it any purpose or delegate to it any medical staff function consistent with these bylaws. Each special committee may elect a chair if none has been designated by the President. A special committee shall report to the President or the Executive Committee, as directed and may be dissolved by the President at any time. Special committees shall meet on an ad hoc basis as required and shall report all conclusions, recommendations and findings to the Executive Committee.

8.1.3 Membership of Committees. Except as specifically provided in this Article VIII, all members of committees of the medical staff shall be members of the active medical staff. Members of the medical staff shall be provided the opportunity to express their preferences as to the committee(s) on which they serve. Unless otherwise provided herein, the chair and members of each standing committee shall be appointed annually by the President, in consultation with the Vice President. In years in which a new President is selected, the incoming President shall appoint the committee chairs and members. Committee members who are not members of the active medical staff shall be appointed by the President and shall not be eligible to vote at committee meetings unless otherwise provided herein. Hospital Administration may

be invited to attend committee meetings and may participate in any such meeting but shall not be eligible to vote.

8.2 Executive Committee

8.2.1 Composition. The Executive Committee shall consist of the following: 1) voting members: President, Vice President, Secretary, Treasurer and the chair of each department of the medical staff or vice chair in the absence of the chair; and 2) non-voting members: the Medical Director, the Vice President of Nursing, the President/Chief Executive Officer and/or his designee.

8.2.2 Terms. Voting members of the Executive Committee may serve for a maximum of four (4) consecutive years in the same capacity. Voting members of the Executive Committee shall be elected for an initial two (2) year term and may be subsequently re-elected for one (1) two-year term.

8.2.3 Duties. The Executive Committee shall represent and act on behalf of the medical staff between meetings of the organized medical staff, subject to such limitations as may be imposed by these bylaws. The Executive Committee shall meet at least ten (10) times per year.

The duties of the Executive Committee shall be: to establish the Rules and Regulations of the medical staff subject to a majority vote of the medical staff at a regularly scheduled medical staff meeting (as described in Section 7.3.5), to coordinate the activities and general policies of the clinical departments; to review and act upon committee reports; to implement policies of the medical staff in cooperation with the departments; to provide liaison between the medical staff and the President/Chief Executive Officer and the Board of Directors on matters relating to patient care and issues relating to the medical staff, including peer review activities, accreditation matters, regulatory body statements of deficiency, and plans of correction; to recommend action to the President/Chief Executive Officer on matters of a medico-administrative nature; to review the credentials of all applicants for appointment and to make recommendations for medical staff membership, assignment to departments and delineation of clinical privileges; to review information regarding the performance and clinical competence of medical staff members and other practitioners with clinical privileges and to make recommendations for reappointment and renewal or changes in clinical privileges; to promote professionally ethical conduct and competent clinical performance of all members of the medical staff through initiation of and/or participation in corrective action proceedings as set forth in Article IX of these bylaws; to report at each meeting of the medical staff; to uphold the bylaws and rules and regulations of the medical staff; to maintain constant supervision and control over the character and quality of medical and surgical care rendered by each member of the medical staff and allied health professional staff and to utilize the reports of pertinent committees for the purpose of peer review; and to perform such other functions as may be delegated to the Executive Committee by the medical staff or its officers. Executive session may be called either by the chair of the Executive Committee or by a vote of at least fifty percent (50%) of the voting members present. Executive session shall be limited to voting members of the Executive Committee.

Except with respect to budgeted items, the Executive Committee shall use its own judgment in spending medical staff money each year under one thousand dollars ($1,000) per item and ten thousand dollars ($10,000) in the aggregate, with the exception of the compensation paid to

Department Chairs and Officers of the Medical Staff. **The following amounts were approved by vote of the Medical Staff on March 11, 2014:**

President - $2,000 per year
Vice President - $2,000 per year
Treasurer - $1,000 per year
Secretary - $1,000 per year
Chair of Internal Medicine, Family Medicine and Surgery - $2,000 per year
Chair of all other departments - $1,000 per year

8.2.4 Removal. Members of the Executive Committee hold such membership by virtue of their positions, as described above. If a member of the Executive Committee of the Medical Staff no longer holds such position because he resigns such position or is removed as described herein, such individual will no longer be a member of the Executive Committee of the Medical Staff. ***Amended MS 9/13/11***

8.3 Bylaws Committee

The bylaws committee shall consist of at least five (5) voting members of the medical staff of Mary's Avenue Campus and (5) voting members of the medical staff of the Broadway Campus Hospital. The bylaws committee shall be responsible for making recommendations relating to revisions to and updating the bylaws and the rules and regulations of the medical staff. The bylaws committee shall meet at least annually to review the bylaws and make written recommendations to the medical staff.

8.4 Credentials Committee

The Credentials membership shall last five (5) years and may be renewed. If a member misses fifty-percent (50) of the meetings during a single year, that member will be removed from the committee and replaced. The Medical Staff President will appoint members to the committee. The credentials committee shall review the credentials of all applicants for appointment and reappointment and make recommendations for medical staff membership and delineation of clinical privileges in accordance with Articles IV and V of these bylaws and shall undertake such other activities related to credentialing as are specified in Articles IV and V herein; shall review the recommendations of department chairs regarding medical staff membership and delineation of clinical privileges; shall investigate any alleged breach of professional ethics or other impairment of credentials that is reported to it; and shall review reports that are referred by the Executive Committee, medical records, or quality council or by the President. The credentials committee shall hold at least six (6) meetings per year and additional meetings as necessary. ***Amended by MS 9.9.14 and approved by BOD***

8.5 Pharmacy, Nutrition and Therapeutics Committee

8.5.1 The President of the Medical Staff shall select a chairman of the Pharmacy, Nutrition and Therapeutics Committee (PNT) from among the members. The Pharmacist, or his/her designee, will serve on the PNT Committee without a vote.

8.6 Quality Council

8.6.1 The quality council shall be comprised of: (1) the Department Chairman or Vice Chairman, as determined by the Department Chairman, from each department; (2) a member of the Board of Directors, without a vote; and (3) the Vice President of the Medical Staff. The President of the Medical Staff shall select a chairman of the Quality Council from among the members and may appoint three physician members to the Quality Council. Representatives from quality assurance, administration and nursing may attend meetings as support staff at the request of the chairman of the Quality Council. The quality council shall meet as often as necessary, but not less than four (4) times a year.

8.6.2 The functions of the Quality Council shall be outlined in, and integrated with, the Hospital's Q.A./P.I./R.M Plan and shall include the following:

8.6.2.1 Review the clinical aspects of quality assessment activities of all medical staff departments and committees to determine whether the requirements of the New York State Department of Health regulations and Joint Commission standards are being met and the responsibilities of each are being monitored.

8.6.2.2 Promotion of activities that assure: (1) effective evaluation and improvement of the quality of important aspects of patient care provided by the medical staff; and (2) comparable levels of care for all patients in the Hospital.

8.6.2.3 Review of significant findings arising out of monitoring and evaluation by medical departments and committees of pre-determined indicators, adverse occurrences and mortalities and morbidities.

8.6.2.4 Oversight of the criteria and standards adopted by each medical staff department to incorporate quality assurance, risk management and performance improvement into the delineation of clinical privileges and content of continuing medical education programs.

8.6.3 As part of their duties as members of the Quality Council, each Department Chairperson or Vice Chairperson, as appropriate, shall (1) assure that his/her department is developing criteria for clinical privileges, conducting monthly audits of department quality assurance/performance improvement activities; and (2) report to the Quality Council regarding quality assurance indicators within the department.

8.6.4 The quality council shall assign one (1) representative to serve on the Hospital's Quality Assurance Committee, which shall perform the functions described in the Hospital's bylaws.

8.7 Committee Meetings

Each standing committee of the medical staff shall hold regular meetings as specified in these bylaws. A special committee of the medical staff may hold regular meetings as directed by the President or as determined by the committee. A special meeting of any committee may be called by its chair or at the request of the President or of one-third of the committee members (but not less than two (2) members).

8.7.1 Notice. A committee may, by resolution, set the day, time and place for regular meetings, and no notice of subsequent regular meetings shall be required other than such resolution. Notice of the date, time and place of any special meeting shall be delivered to each member at least three (3) days in advance of such meeting. The attendance of a committee member at a regular or special meeting shall constitute a waiver of notice of such meeting.

8.7.2 Quorum and Action. Twenty-five percent (25%) of the members of a committee, but not less than two (2) members, shall constitute a quorum at any regular or special meeting of the committee. The vote of a majority of the committee members present at a meeting at which a quorum exists shall be the action of the committee. Action of a committee may be taken without a meeting by unanimous written consent signed by each committee member entitled to vote on the matter.

8.7.3 Minutes. Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of committee members and of all votes taken on any matter. The minutes shall be signed by the chair and maintained in a permanent file of the committee. The minutes of each committee meeting shall be promptly submitted to the Executive Committee.

8.7.4 Attendance Requirement. Each member of the medical staff shall be required to attend not less than one-third (1/3) of all meetings of each medical staff or Hospital committee on which he serves in each year, unless excused by the committee chair for good cause. Members of committees may be subject to disciplinary action for failure to attend committee meetings as provided herein.

8.7.5 Status of Committees. To the extent that each standing and special committee is charged with responsibility for evaluation and improvement of the quality of care rendered in the Hospital, within the purview and meaning of New York Education Law Section 6527(3), the proceedings and the records of such committee shall be confidential and shall not be disclosed except as required by law.

ARTICLE IX

CORRECTIVE ACTION

9.1 Internal Reporting Process

9.1.1 Concerns and complaints regarding the clinical practice or competence of a privileged practitioner or allied health professional may be made by medical staff members, allied health professionals, hospital staff, patients and visitors. Such complaints or concerns should be sent or forwarded to the Medical Director who shall, within seventy-two (72) hours, initiate investigation into the matter and refer to the appropriate committee pursuant to policy approved by the Medical Staff and the Board of Directors. If, as a result of such investigation, corrective action or focused professional peer evaluation is recommended, such recommendation will be acted upon.

9.2 Basis for Corrective Action

9.2.1 Grounds. A practitioner shall be subject to corrective action if the Executive Committee or the Board of Directors determines that such practitioner has engaged in conduct which:

9.2.1.1 May adversely affect or be detrimental to the safety of patients or others within the Hospital, or the delivery of quality care; or

9.2.1.2 Raises material concerns regarding any of the practitioner's professional competence; or

9.2.1.3 Is disruptive of the operation of the Hospital as a result of the manifestation of unprofessional behavior; or (see policy on Code of Conduct)

9.2.1.4 Fails to satisfy the obligations of the practitioner contained herein which the practitioner agrees to as a condition of applying for, accepting or exercising privileges.

9.2.2 Conflicts of Interest. In the event that any medical staff officer, medical staff member, administrative officer, member of the Board of Directors, or other individual who is selected or assigned to participate in a corrective action, a summary suspension, a hearing, or an appellate review under these bylaws has an actual or apparent conflict of interest, such individual shall be disqualified from participation in such proceeding. An actual or apparent conflict of interest shall include but shall not be limited to circumstances under which the individual is or may be materially involved in any incident or activity giving rise to the request for corrective action; where the individual has substantial economic ties with the practitioner who is the subject of the corrective action; or where the individual is in direct economic competition with the subject of the corrective action.

9.3 Requests for Corrective Action

A written request for corrective action may be made by the Medical Director, the President/Chief Executive Officer, the Board of Directors, the HA Board of Directors or any medical staff member or group of members, and shall:

1. Identify the specific conduct which constitutes the grounds for the request; and

2. Be submitted to the President, who shall be deemed to be acting as an agent of the Executive Committee in all matters relating to such corrective action. If the request concerns the President, the request shall be submitted to the Chair of the Board of Directors, who shall then assume the responsibilities of the President under this Article IX.

9.3.1 Notification. The President shall promptly notify the President/Chief Executive Officer and Chairperson of the Board of Directors in writing of all requests for corrective action and keep the President/Chief Executive Officer and Chairperson of the Board of Directors fully informed of all action in connection therewith.

9.3.2 Grievances. If a practitioner believes that his rights under these bylaws have been violated, the practitioner may report the matter to the President, and shall have all rights afforded to practitioners under these bylaws.

9.4 Investigation

9.4.1 Appointment of Ad Hoc Committee. Unless otherwise provided herein, the President, upon receipt of a request for corrective action, shall immediately appoint an ad hoc committee to investigate the matter.

9.4.2 Ad Hoc Committee Investigation. The ad hoc committee shall exercise due diligence to complete its investigation, and not later than fifteen (15) days after its investigation has been completed, the ad hoc committee shall make a written report of its investigation to the Executive Committee, which report shall include a recommendation for: (a) no action, (b) corrective action as described in 9.6 or (c) focused professional peer evaluation in accordance with Medical Staff policy.

9.4.3 Notice to Practitioner; Nature of Investigation. The President shall give the practitioner notice that an investigation is being conducted and the practitioner shall be given a reasonable opportunity to provide information to the committee. The ad hoc committee shall attempt to conduct interviews with persons involved (including the practitioner); however, such investigation shall not constitute a "hearing" as that term is used in Article X, nor shall the procedural rules with respect to such hearings apply.

9.5 Executive Committee Action

At a special meeting or next regular meeting following receipt of the ad hoc committee's report, the Executive Committee shall consider the report and adopt, modify, or reject the report, either in part or entirely. If the Executive Committee directs the imposition of a corrective action that is based on a practitioner's professional competence and/or conduct and would adversely affect a Medical Staff member's privileges, the corrective action shall not take effect until the practitioner has exercised or waived the right to a hearing as provided in Article X. The President shall give the practitioner prompt written notice of the decision of the Executive Committee, which shall describe the corrective action, if any.

9.6 Types of Corrective Action

9.6.1 Executive Committee Determination of Corrective Action. The Executive Committee shall determine the nature and conditions of each corrective action and may direct counseling, education, letter of admonition, warning or reprimand, concurrent or prospective reviews or other action which does not limit the practitioner's privileges. The Executive Committee may also direct any combination of the following types of corrective action ("corrective action"), all being independent and none being a prerequisite to any other:

1. Probation for a specified period;

2. Required supervision or consultation under specified circumstances and for a specified period of time;

3. Reduction, limitation, modification or suspension of delineated privileges;

4. Change in staff category; or

5. Revocation of appointment.

9.6.2 NPDB. In compliance with the Health Care Quality Improvement Act, the Hospital shall report to the NPDB any final professional review action that (a) is based upon quality of care or professional competence or conduct that adversely affects, or could adversely affect, the health or welfare of a patient; and (b) adversely affects a practitioner's clinical privileges for a period longer than thirty (30) days. The Hospital shall also report revisions to such actions previously reported.

9.6.3 Office of Professional Medical Conduct and the Department of Education. In compliance with the New York State Regulations Part 405.3, the Hospital shall report to the Office of Professional Medical Conduct or the Department of Education, as applicable, within 30 days of the occurrence of the denial, suspension, restriction, termination or curtailment of training, employment, association or professional privilege for reasons related in any way to any of the following: (i) alleged mental or physical impairment, incompetence, malpractice, misconduct or endangerment of patient safety or welfare; (ii) voluntary or involuntary resignation or withdrawal of association or of privileges with the hospital to avoid the imposition of disciplinary measures; (iii) the receipt of information concerning a conviction of a misdemeanor or felony.

9.7 Follow up and Further Action

9.7.1 Department Chair Oversight. Any corrective action shall be executed under the control of the Executive Committee, and under the supervision of the appropriate department chair who shall report to the Executive Committee on the effect of the corrective action.

9.7.2 Further Corrective Action. If the department chair, the President, the Medical Director or the President/Chief Executive Officer reasonably determines that the corrective action or other action imposed has not had the proper remedial effect, further corrective action may be requested utilizing the procedures specified in this Article IX.

9.7.3 Action Reported in Credentials File. A report of each corrective action or other action imposed by the Executive Committee shall be included in the credentials file of the affected practitioner.

9.8 Summary Suspension

9.8.1 Criteria and Initiation. In the event that the President, the Medical Director, the President/Chief Executive Officer or the chair of a department determines after reasonable inquiry that the conduct of a practitioner poses an imminent danger, and that immediate action is required in order to protect the well-being of patients, employees, visitors, or other practitioners in the Hospital, such practitioner's privileges may be immediately suspended, in whole or in part, by the President, the Medical Director, the President/Chief Executive Officer, or the chair of a department in which the practitioner has privileges.

The summary suspension shall be effective immediately upon imposition. The individual imposing such suspension shall promptly give notice of the suspension to the practitioner, the President/Chief Executive Officer, the chair of each department in which the practitioner has

privileges, the President, the Executive Committee, and the Chair of the Board of Directors. Notice to the suspended practitioner shall be in writing, and shall be given by personal delivery or, if personal delivery is not reasonably practicable, by certified mail with return receipt requested.

9.8.2 Continuation of Suspension and Board Action

9.8.2.1 Within fifteen days of a summary suspension, the Executive Committee shall review the matter at a special or regular meeting of the Executive Committee.

9.8.2.2 If the Executive Committee recommends that the summary suspension be upheld, the practitioner shall be offered a hearing in accordance with Article of these bylaws.

9.8.2.3 If the Executive Committee recommends that the summary suspension be terminated, the recommendation shall be forwarded to the Board of Directors, or an appropriate committee thereof, for its review, which shall occur within fifteen days. If the Board of Directors votes to continue the summary suspension or modify the suspension such that there is still a limitation on the practitioner's privileges, the practitioner is entitled to a hearing in accordance with Article X of these bylaws. If the Board of Directors decides to vacate the summary suspension, it shall be automatically and immediately terminated.

9.8.2.4 Immediately upon the imposition of a suspension, the President or a department chair designated by the President, shall have the authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

9.8.3 Mental or Physical Examination. Upon summary suspension of a practitioner's privileges, the practitioner may be required by the President, Medical Director or the President/Chief Executive Officer to submit to mental or physical examinations which are directly pertinent to the determination of whether the practitioner is suffering from a condition that poses an imminent danger to patients or others (including the practitioner); or which interferes with, or presents a substantial probability of interfering with, patient care, a practitioner's exercise of privileges, or the assumption and discharge of a practitioner's required responsibilities; provided, however, that in no event shall this provision be interpreted, used or applied to discriminate against a "qualified individual with a disability" within the meaning of the Americans With Disabilities Act. The practitioner may select from among a panel of New York State licensed physicians or laboratories designated by the Executive Committee for the performance of such examinations. The testing or examination reports, or any refusal by the practitioner to submit to testing or examination, shall be made a part of the record of the summary suspension and may be considered in proceedings arising therefrom.

9.9 Automatic Suspension

The actions listed below shall result in automatic suspension of privileges. Whenever the actions specified in 9.9.2, 9.9.3, 9.9.4 or 9.9.6 occur, the practitioner must immediately report it to the

Medical Director. A failure to report without good cause, shall be grounds for revocation of medical staff appointment, clinical privileges and any medical staff offices and positions held, as applicable. Automatic suspension as described in this Section 9.9 shall not give rise to a hearing under Article X of these bylaws.

9.9.1 Incomplete Medical Records. Medical Records of discharged patients must be complete within thirty (30) days of patients' discharge from the Hospital. In the event of a practitioner's unexcused failure to complete medical records of discharged patients within thirty (30) days of the patients' discharge from the Hospital, the Hospital shall notify the practitioner of such delinquency, and a suspension of the practitioner's admitting privileges may be imposed until the delinquency has been cured. ***Refer to Health Alliance Delinquent Medical Record Policy***

9.9.2 Revocation or Suspension of License. A practitioner whose license, registration, certificate, or legal credentials authorizing practice in the State of New York is suspended or surrendered is automatically and immediately suspended from practicing in the Hospital. In the case of revocation of the legal credentials authorizing practice in the State of New York, the practitioner's privileges hereunder are automatically terminated. Restoration of medical staff appointment and privileges may only be accomplished through the new applicant process**.**

9.9.3 Drug Enforcement Agency ("DEA") Number. A practitioner whose DEA number is revoked, suspended, surrendered or restricted or is under sanction by CMS, is immediately and automatically divested of the right to prescribe medication covered by the number, but may continue to provide services in the Hospital within the scope of his privileges. As soon as possible after such automatic suspension, the Executive Committee shall convene to consider the facts under which the DEA number was revoked or suspended, and may then take such further action as it deems appropriate pursuant to these bylaws.

9.9.4 Professional Liability Insurance. Whenever a practitioner fails to maintain the minimum amount of professional liability insurance required by these bylaws, the practitioner's staff appointment and clinical privileges are immediately and automatically suspended. In order to have his appointment and privileges reinstated, a practitioner must submit to the Medical Director a certified copy of a current insurance certificate which indicates any limitations and proves that there are no lapses in coverage. The practitioner must submit a written summary of relevant activities during the period of suspension, if so requested. If the Hospital does not learn of the loss of professional liability insurance until after the practitioner has already reinstated his professional liability coverage, the practitioner has thirty (30) days to provide the Hospital with evidence that he had no lapse in coverage. Failure to provide the evidence within that time frame will result in automatic suspension.

9.9.5 Annual Acknowledgment Statement/Proof of Health Status. Whenever a practitioner fails to submit an annual acknowledgement statement/proof of health status in accordance with Hospital Policy, his clinical privileges and staff appointment are immediately and automatically suspended until such documentation is submitted to the Medical Staff Office.

9.9.6 Federal/State Sanctions. A practitioner who loses his right to participate in federally funded health care programs (e.g., Medicare, Medicaid) is automatically and

immediately suspended from practicing in the Hospital until such practitioner is deemed eligible to participate in such programs.

9.10 Effect of Suspension on Rights

Suspension of a practitioner's privileges shall, during the period of such suspension, suspend the practitioner's right to exercise any rights allowed to practitioners hereunder, including the right to attend or vote at meetings of the medical staff or department or committees thereof or to hold office, but shall not suspend or curtail such member's rights under Article X.

9.11 Notices to Practitioners

Except as otherwise set forth herein, any notices required to be given to a practitioner as provided in Articles IX and X of these bylaws shall be by certified mail return receipt requested; provided however, that failure to provide notice in such manner shall not invalidate the notice where there is substantial evidence that the notice was actually received by the practitioner in a timely manner.

ARTICLE X

HEARING AND APPELLATE REVIEW

10.1 Right to a Hearing

Unless otherwise provided by these bylaws or by contract, whenever the Executive Committee or the Board of Directors makes a recommendation or takes action that: (a) will adversely affect an applicant's or medical staff member's application for appointment or reappointment to, or status as a member of, the medical staff, or his exercise of clinical privileges; and (b) results from issues related to professional competence or conduct, he shall be entitled to a hearing before an ad hoc committee of the medical staff. If the recommendation of the Executive Committee or the Board of Directors following such hearing is still adverse to the affected applicant or medical staff member, he shall then be entitled to appellate review by the Board of Directors.

10.2 Notice of Adverse Action and Right to a Hearing

10.2.1 Notice. An aggrieved practitioner against whom an adverse action is proposed to be taken shall promptly be given notice of the action by the President/Chief Executive Officer.

10.2.2 Content. The notice shall include a copy of this Article X and shall include:

10.2.2.1 The proposed action;

10.2.2.2 The reason(s) for the proposed action;

10.2.2.3 That the practitioner has the right to request a hearing on the proposed action;

10.2.2.4 That a medical staff member may request an accelerated hearing in certain circumstances.

10.2.2.5 That the practitioner has a period of thirty (30) days from the date of the notice to request a hearing; and

10.2.2.6 A summary of the practitioner's rights at the hearing as described in Section 10.7.9 below.

10.3 Request for Hearing/Failure to Request

10.3.1 Request for Hearing. An aggrieved practitioner shall have thirty (30) days from the date of the notice of the adverse action to file a written request for a hearing. The request shall be delivered in person or sent by certified mail, return receipt requested, to the President/ Chief Executive Officer.

10.3.2 Failure to Request a Hearing. Failure to request a hearing within the time and in the manner prescribed waives the right to a hearing. The waiver shall constitute an acceptance of the adverse action taken, unless the initial action is changed to a more severe adverse action by a body with higher authority than the body taking the initial adverse action. In such case, the aggrieved individual shall again be offered a hearing.

10.4 Hearing Prerequisites

Upon receipt of a timely request for a hearing, the President/Chief Executive Officer shall deliver the request to the presiding officer of the Executive Committee or the Board of Directors, whichever such body took the adverse action. The presiding officer shall then promptly schedule a hearing and give the practitioner notice of the place, time and date of the hearing, which date shall not be less than thirty (30) days nor more than sixty (60) days after the date of such notice. This notice shall also include a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body, the acts or omissions with which the practitioner is charged, a list of specific or representative charts being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision. Postponement of hearings beyond the time set forth in these bylaws shall be made only with the approval of the hearing officer (as described in Section 10.5.3). Granting of such postponements shall only be for good cause shown.

In instances where the affected medical staff member is under summary suspension, the medical staff member may waive his right to have the hearing held not less than thirty (30) days after the date of notice of hearing by requesting an earlier hearing date in which event the hearing shall be held not later than thirty (30) days from the date of receipt of the hearing request. The medical staff member shall be advised by the President/Chief Executive Officer of his right to request an accelerated hearing in the notice. In the event that the medical staff member wishes to exercise this option, he shall include a specific request for an accelerated hearing in his written request for a hearing. In such case, the President/Chief Executive Officer or his designee shall arrange for a hearing and give notice of the same as soon as practical. The medical staff member's failure to expressly request an accelerated hearing in this manner shall be deemed a waiver of his right to this option.

10.5 Hearing Committee

10.5.1 Adverse Action by Executive Committee. When a hearing relates to an adverse action of the Executive Committee, such hearing shall be conducted by a hearing committee of

not less than three (3) practitioners appointed in the same manner as the ad hoc committee described in Section 9.3.1 above. One of the members so appointed shall be designated as chair by the individual appointing such committee. No medical staff member who participated in the initiation or consideration of the adverse recommendation shall be appointed a member of this ad hoc hearing committee.

10.5.2 Adverse Action by Board of Directors. When a hearing relates to an adverse action of the Board of Directors that is contrary to the recommendation of the Executive Committee, the Board of Directors shall appoint a hearing committee of three (3) members of the Board of Directors to conduct such a hearing and shall designate one of the members of such committee as chair.

10.5.3 Hearing Officer. A hearing officer shall be appointed by the President/Chief Executive Officer from within or without the medical staff. The hearing officer may be an attorney-at-law. The hearing officer shall not participate in deliberations or vote on any action by the hearing committee. The Hospital shall pay for the costs and expenses associated with the hearing officer.

10.6 Hearing Officer's Duties

The hearing officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The hearing officer also shall determine the order of procedure during the hearing and shall make all rulings, including the admissibility of evidence, with respect to conduct of the proceedings. However, the hearing committee by a majority vote may overrule the hearing officer with respect to a ruling on the conduct of the proceeding.

10.7 Conduct of Hearing

The general conduct of the hearing shall be as follows:

10.7.1 Presence of Hearing Committee Members. Normally, all of the hearing committee members shall be present during the hearing. However, it is within the hearing committee's sole discretion to permit a member to be absent under specified terms and conditions, provided that at least two-thirds (2/3) of the members of the hearing committee are present when a hearing takes place.

10.7.2 Presence of Practitioner. The personal presence of the aggrieved practitioner shall be required. Such aggrieved practitioner's failure to appear without good cause or failure to proceed at the hearing shall be deemed a waiver of the right to a hearing and shall be deemed acceptance of the adverse action.

10.7.3 Representation by Legal Counsel. The hearings provided for in these bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct. The aggrieved practitioner and Hospital shall be entitled to be accompanied and/or represented at the hearing by an attorney or any other person of each party's choice.

10.7.4 List of Witnesses and Exhibits. Under directions from the hearing officer, each party shall give to the other party such advance notice of its intended witnesses, and such

advance copies of or a list of its intended exhibits, as may be practicable. The goal shall be to expedite the proceedings and to minimize the element of surprise as an advantage to either party.

10.7.5 Recesses. For the convenience of the participants or for the purpose of obtaining new or additional evidence, the hearing officer may recess, and reconvene without additional notice.

10.7.6 Hearing Closed. The hearing shall be closed to all but the necessary parties unless the hearing officer determines that the attendance of other parties is required for the fair conduct of the hearing.

10.7.7 Hearing Record. A record of the hearing shall be made and shall be paid for by the Hospital. Each party shall be given one copy of the transcript upon request.

10.7.8 Evidentiary Rules. The hearing need not be bound by the strict rules of evidence and the hearing officer may admit any relevant evidence.

10.7.9 Parties' Rights During Hearing. During a hearing, both parties shall have the following rights: to call and examine witnesses; to introduce written evidence; to cross-examine witnesses on any matter relevant to the issues of the hearing; to challenge any witness; and to rebut any evidence. The aggrieved practitioner may testify and may be requested to answer questions posed by the other party's representative and the hearing committee. The personal appearance of each witness normally will be required to assure the opportunity for cross-examination and examination by the hearing committee. In extraordinary circumstances, the hearing committee may receive an individual's sworn written statement or other form of proof in lieu of a personal appearance.

10.7.10 Oral Evidence. Oral evidence shall be taken only upon oath or affirmation administered by a notary public in the State of New York.

10.7.11 Exhibits. A copy of each exhibit received by the hearing committee shall be supplied to the other party by the offering party.

10.7.12 Termination of Hearing; Deliberations. After all oral and written evidence and argument has been presented, the evidentiary portion of the hearing shall be declared closed. The hearing committee shall conduct its deliberations privately.

10.8 Hearing Committee Report

Within a reasonable time after the closing of the hearing, but in no event to exceed thirty (30) days, the hearing committee shall make a written report including the factual basis for its recommendation and shall forward it to the Chairman of the Board of Directors or President depending on the body whose adverse action occasioned the hearing, with copies to the President, the President/Chief Executive Officer, the pertinent department chair, and the practitioner. The hearing committee shall recommend that the original adverse action be affirmed, modified or reversed.

10.9 Action on Hearing Committee Report

Within thirty (30) days after receipt of the hearing committee report, the body whose adverse action occasioned the hearing shall affirm, modify, or reverse its original decision. The practitioner shall be given notice of the body's written recommendation or decision within seven (7) business days, with copies to the President, the President/Chief Executive Officer, the hearing officer and the members of the hearing committee. In the case of a continued adverse recommendation by the Executive Committee in which an appellate review is not requested as described in Section 10.10 below, the recommendation along with the hearing committee report shall be forwarded to the Board of Directors for final determination.

10.10 Appellate Review

10.10.1 Request for Appellate Review. After considering the hearing committee report, if the recommendation of the original body is still adverse to the aggrieved practitioner, the practitioner may request appellate review by the Board of Directors by sending written notice to the President/Chief Executive Officer by certified mail return receipt requested. The notice shall set forth the alleged errors or omissions in the prior proceedings which merit consideration on appeal. Such notice must be received by the President/Chief Executive Officer within fourteen (14) days of date that notice of the written recommendation or decision from the Executive Committee or the Board of Directors, as the case may be, was sent to the aggrieved practitioner.

10.10.2 Determination of Board of Directors. The Board of Directors shall acknowledge the request within fifteen (15) days of receipt of the notice of appeal. The Board of Directors shall act within fifteen (15) days of said acknowledgment, for all purposes of this Section 10.11.2, by the full Board, or by an appellate review committee of not fewer than five (5) Directors appointed by the Chairperson of the Board of Directors. The Board or the appellate review committee may determine, in its discretion, whether an oral argument will be heard, and whether to permit the parties to be represented by legal counsel. If either party is permitted to have legal representation, the other party shall also be permitted to use legal counsel.

10.10.3 New or Additional Matters on Appeal. New or additional matters or evidence not raised during the original hearing or in the report of the hearing committee, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Board of Directors or the committee thereof appointed to conduct the appellate review shall not be required to consider such new matters or evidence unless it is material.

10.10.4 Report of Recommendation. Within thirty (30) days of adjournment of the appellate review proceeding, the appellate review committee shall prepare its report and recommendation and forward it to the Chairman of the Board of Directors.

10.11 Action by the Board of Directors

If no notice of appeal is timely received, then the Board of Directors shall make a final decision with respect to the adverse action within fifteen (15) days after (i) receipt of the final recommendation from the Executive Committee or, (ii) in the case of an adverse action by the Board of Directors, receipt of the report from the hearing committee. If the practitioner's request for an appeal is timely received, then the Board of Directors shall make a final decision on the

adverse action within thirty (30) days after receipt of the appellate review committee's recommendation.

10.12 Medical-Administrative Positions

The loss of a medical-administrative position, including, but not limited to, chair of a department, officer of the medical staff, or membership on any committee of the medical staff, does not entitle the affected practitioner to any rights provided in this Article X.

10.13 General Provisions

10.13.1 Limitations on Hearings. Notwithstanding any other provisions of these bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter, which shall have been the subject of action by the Executive Committee or Board of Directors.

10.13.2 Immunity from Liability. By requesting a hearing or appellate review, an applicant or medical staff member agrees to be bound by the provisions of the bylaws relating to immunity from liability.

ARTICLE XI

PROCEDURES

11.1 Immunity From Liability

The following provisions of this Section 11.1 shall be express conditions of each practitioner's application for and appointment or reappointment to the medical staff, or exercise of clinical privileges, at the Hospital.

11.1.1 Privilege. Any act, communication, report, recommendation or disclosure, with respect to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law. Such privilege shall extend to members of the Hospital's medical staff, the Board of Directors, HA Board of Directors, other practitioners, Hospital Administration, and third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Section 11.1, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Board of Directors, HA Board of Directors or the medical staff, within the purview of established credentialing and peer review procedures.

11.1.2 Immunity. There shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

11.1.2.1 Such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to (a) application for appointment or clinical privileges, (b) periodic reappraisals for reappointment or clinical privileges, (c) corrective action,

including summary suspension, (d) hearing and appeal procedures, (e) medical care evaluation, (f) utilization review and (g) other Hospital, department or committee activities related to patient care or professional conduct.

11.1.2.2 The acts, communications, reports, recommendations and disclosures referred to in this Section 11.1 may relate to a practitioner's professional qualifications, clinical competence, character, mental or emotional stability, physical condition, ethics or any other matter that might directly or indirectly have an effect on patient care.

11.1.3 Release. In furtherance of the foregoing each practitioner shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this Section 11.1 in favor of the individuals and organizations specified herein, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under state law.

11.1.4 Additional Actions. The consents, authorizations, releases, rights, privileges and immunities provided under Article IV of these bylaws for the protection of practitioners, appropriate Hospital officials and personnel and third parties in connection with applications for appointment to the medical staff, shall also be fully applicable to the activities and procedures described in this Section 11.1.

11.1.5 Indemnification. The Hospital shall indemnify each member of the medical staff, Hospital Administration and other officers and employees from any claim, liability, or demand arising from the making by any such person of a communication covered by this Section 11.1 and shall provide a legal defense to any such person at Hospital expense, provided that such person is not adjudicated in a court of final jurisdiction to have acted with malice or in bad faith in making such communication.

11.1.6 Amendments These bylaws, rules and regulations shall be reviewed at least annually by the bylaws committee. Upon recommendation of the bylaws committee, these bylaws, rules and regulations may be amended at any regular or special meeting of the medical staff duly called after notice to the medical staff members of that purpose, which notice shall include the substance of any recommended change in the bylaws, rules and regulations. Subject to satisfaction of the quorum requirements set forth in Section 7.3.5, a majority of the number of votes received will be required for adoption. Votes will be accepted by hand delivery, fax, or email immediately upon notice of the meeting and for 24 hours after the meeting. Amendments so adopted shall become effective upon approval by the Hospital Board of Directors and the HA Board of Directors. In making such amendments, consideration should be given to keeping these medical staff bylaws identical to, and/or consistent with, the HealthAlliance Hospital: Broadway Campus and/or Mary's Avenue Campus Medical Staff Bylaws.

11.1.7 Urgent Need for Amendment. In cases where there is a **documented** need for an urgent amendment to rules and regulations or policies in order to comply with law, regulation or accreditation standard, the Executive Committee may provisionally adopt, and the Governing Body may provisionally approve such urgent amendment without prior notification of the medical staff. **In such cases, the medical staff will be immediately notified of the provisional amendment through a direct mailing or electronic transmission. If the medical staff, through its President, does not notify the President/CEO of the medical staff's objection to the provisional amendment within ten (10) days of notification, the provisional amendment**

will become permanent. If there is a conflict, the process described below in Section 11.5 is followed and, if applicable, a revised amendment submitted to the Governing Body for action. The provisional amendment shall remain in effect until a revised amendment is adopted by the Governing Body. ***Amended by MS 9.9.14 and approved by BOD***

11.2 Policies

The medical staff may from time to time adopt policies and procedures to describe the implementation of the requirements of these Medical Staff Bylaws. Policies and procedures may be recommended to the Governing Body by a majority vote of the Executive Committee, following communication to the medical staff regarding the proposed policy. Such policies become effective when adopted by the Governing Body and shall be presented to the medical staff at its next scheduled meeting following Governing Body approval. In addition, the Medical Staff, by written submission signed by twenty percent (20%) of its membership, may communicate with, or propose policies directly to, the Governing Body. When amendments or adoption policies are communicated directly to the Governing Body, the Medical Staff must first communicate the proposed amendment to the Executive Committee. ***Amended MS 9/13/11***

11.3 Adoption

Subject to the satisfaction of a quorum stated in Section 7.3.5, a majority of the number of votes received will be required for adoption. Votes will be accepted either by hand deliver, fax, or email immediately upon notice of the meeting and for 24 hours after the meeting. These bylaws, rules and regulations shall become effective upon adoption by the medical staff and Board of Directors, and approval of the HA Board of Directors. They, along with the policies referenced in Section 11.2, shall, when adopted, be equally binding on the HA Board of Directors, Board of Directors, the Hospital, and the medical staff. ***Amended Quorum MS 3/28/13***

11.5 Conflicts between the Medical Staff and the Executive Committee

If a conflict arises between the medical staff and the Executive Committee, including a conflict involving a proposal to adopt a Rule and Regulation or policy, an ad-hoc Conflict Resolution Committee shall meet to identify potential resolutions to the conflicted issues. The ad hoc Conflict Resolution Committee shall consist of the officers of the Medical Staff, the Chief Medical Officer, and one nomination from each Department Chair. The President will have the ability to choose three committee members from those nominees. For conflicts involving the Medical Staff Bylaws, Rules and Regulations or policy, the Chairperson of the Bylaws Committee will be included. Such ad hoc committee shall meet prior to any action related to the conflicted issue or prior to the submission of a disputed policy to the Governing Body. If the ad hoc Conflict Resolution Committee is unable to resolve the issue in a manner that is acceptable to both the medical staff and the Executive Committee, the matter, including the viewpoints of both the medical staff and the Executive Committee, shall be referred to the Governing Body for action. The ad hoc Conflict Resolution Committee may be convened upon request of the President, any member of the Executive Committee or a by petition of twenty-five (25%) percent of the voting members of the Medical Staff. ***Amended MS 9/13/11and approved by BOD 9/11***

AMENDMENTS adopted by the active medical staff on November 17, 2009
AMENDMENTS adopted by the active medical staff on February 8, 2011
AMENDMENTS adopted by the active medical staff on September 13, 2011
AMENDMENTS adopted by the active medical staff on January 10, 2012
AMENDMENTS adopted by the active medical staff on March 28, 2013
RULES AND REGULATIONS approved by medical staff March 28, 2013
AMENDMENTS adopted by the active medical staff on January 14, 12014
AMENDMENTS adopted by the active medical staff on March 11, 2014
AMENDMENTS adopted by the medical staff on January 13, 2014
AMENDMENTS adopted by the active medical staff on September 9, 2014
RULES AND REGULATIONS adopted by the medical staff in May 2015
AMENDMENTS adopted by the active medical staff on May 21, 2015
AMENDMENTS adopted by the active medical staff on November 10, 2015

Martin Cascio, MD
President of the Staffs

Michael Sheran, MD
Secretary of the Staffs

AMENDMENTS approved by the Governing Body on September 7, 2011
AMENDMENTS approved by the Governing Body on October 5, 2011
AMENDMENTS approved by the Governing Body on January 30, 2012
AMENDMENTS approved by the Governing Body on May 2, 2013
RULES & REGULATIONS approved by the Medical Staff May 2, 2013
AMENDMENTS approved by the Governing Body in March 2014
AMENDMENTS approved by the Governing Body in November 2014
AMENDMENTS approved by the Governing Body in June 2014
RULES AND REGULATIONS approved by the Governing Body in February 2015
AMENDMENTS approved by the Governing Body in June 2015
AMENDMENTS approved by the Governing Body in November 2015

Michael Ryan, Chair
Chair, Board of Directors