BYLAWS OF THE MEDICAL STAFF
WAVERLY HEALTH CENTER
Waverly, Iowa

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TABLE OF CONTENTS

Table of Contents

PREAMBLE **13**

DEFINITIONS **14**

Article I: NAME **16**

Article II: PURPOSES **17**

2.1 PURPOSES **17**

2.2 BYLAWS, RULES AND REGULATIONS **17**

Article III: MEMBERSHIP **18**

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP **18**

3.1-1 IN GENERAL **18**

3.1-2 ONGOING EVALUATION OF NEEDS **18**

3.2 QUALIFICATIONS FOR MEMBERSHIP **18**

3.2-1 GENERAL QUALIFICATIONS **18**

3.2-2 PARTICULAR QUALIFICATIONS **19**

3.2-3 EFFECT OF OTHER AFFILIATIONS **20**

3.3 NONDISCRIMINATION **20**

3.4 CONTRACTED AND HOSPITAL-BASED SPECIALTY PRACTITIONERS **20**

3.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP **20**

3.6 DURATION OF APPOINTMENT **22**

3.7 LEAVE OF ABSENCE **23**

3.7-1 LEAVE STATUS **23**

3.7-2 TERMINATION OF LEAVE **23**

Article IV: CATEGORIES OF THE MEDICAL STAFF **24**

4.1 CATEGORIES 24

4.2 ACTIVE MEDICAL STAFF 24

4.2-1 QUALIFICATIONS 24

4.2-2 PREROGATIVES 24

4.2-3 RESPONSIBILITIES 25

4.3 COURTESY STAFF 25

4.3-1 QUALIFICATIONS 25

4.3-2 PREROGATIVES 26

4.3-3 RESPONSIBILITIES 26

4.4 CONSULTING STAFF 26

4.4-1 QUALIFICATIONS 26

4.4-2 PREROGATIVES 27

4.4-3 RESPONSIBILITIES 27

4.5 PROVISIONAL STAFF MEMBER 27

4.5-1 FOR INITIAL APPOINTMENTS 27

4.5-2 FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES ..28

4.5-3 TERM OF PROBATIONARY PERIOD 28

4.6 HONORARY STAFF 29

4.6-1 QUALIFICATIONS 29

4.6-2 PREROGATIVES 29

4.7 ALLIED PROFESSIONAL STAFF 29

4.7-1 QUALIFICATIONS 29

4.7-2 PREROGATIVES 29

4.7-3 RESPONSIBILITIES 30

4.9 LIMITATION OF PREROGATIVES 31

Article V: MEDICAL AND SURGICAL ASSISTANTS; STUDENTS, RESIDENTS, AND INTERNS....32

5.1 MEDICAL AND SURGICAL ASSISTANTS....32

Article VI: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT....33

6.1 GENERAL PROCEDURE....33

6.1-1 PRE-APPLICATION REQUIREMENT....33

6.1-2 GROUNDS FOR NOT PROVIDING APPLICATION FORM....33

6.1-3 NATURE OF MEDICAL STAFF CONSIDERATION....34

6.2 APPLICATION FOR APPOINTMENT....35

6.2-1 CONTENT....35

6.2-2 EFFECT OF APPLICATION....36

6.3 PROCESSING THE APPLICATION....38

6.3-1 APPLICANT'S BURDEN....38

6.3-2 VERIFICATION OF INFORMATION....38

6.3-3 MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION....39

6.3-4 APPOINTMENT RECOMMENDATION....39

6.3-5 BASIS FOR APPOINTMENT....39

6.3-6 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION....40

6.3-7 ACTION BY THE GOVERNING BOARD....40

6.3-8 NOTICE OF FINAL DECISION....42

6.3-9 REAPPLICATION AFTER ADVERSE DECISION DENYING APPLICATION, ADVERSE CORRECTIVE ACTION DECISION, OR RESIGNATION IN LIEU OF MEDICAL DISCIPLINARY ACTION....42

6.4 REAPPOINTMENTS....43

6.4-1 APPLICATION FOR REAPPOINTMENT; SCHEDULE FOR REVIEW..43

6.4-2 VERIFICATION OF INFORMATION....43

6.4-3 MEDICAL EXECUTIVE COMMITTEE ACTION/ BOARD ACTION 44

6.4-4 REAPPOINTMENT RECOMMENDATION 44

6.4-5 BASIS FOR REAPPOINTMENT 45

6.4-6 FAILURE TO FILE REAPPOINTMENT APPLICATION 45

6.4-7 FAILURE TO REQUEST REINSTATEMENT 45

Article VII: CLINICAL PRIVILEGES 47

7.1 EXERCISE OF PRIVILEGES; REDETERMINATION OF PRIVILEGES 47

7.2 DELINEATION OF PRIVILEGES IN GENERAL 47

7.2-1 REQUESTS 47

7.2-2 BASIS FOR PRIVILEGE DELINEATION 47

7.2-3 PROCEDURE 48

7.3 SPECIAL CONDITIONS 48

7.3-1 APPLICABLE TO DENTAL AND PODIATRIC PRIVILEGES AS WELL AS TO CHIROPRACTORS AND OPTOMETRISTS 48

7.3-2 APPLICABLE TO MIDLEVELS AND ALLIED PROFESSIONALS 48

7.4 TEMPORARY PRIVILEGES 49

7.4-1 CONDITIONS 49

7.4-2 CIRCUMSTANCES 49

7.4-3 TERMINATION 50

7.4-4 RIGHTS OF THE PRACTITIONER 51

7.5 EMERGENCY PRIVILEGES 51

7.7 TELEMEDICINE PRIVILEGES 52

Article VIII: CORRECTIVE ACTION 53

8.1 ROUTINE CORRECTIVE ACTION 53

8.1-1 CRITERIA FOR INITIATION 53

8.1-2 PEER REVIEW CONFIDENTIALITY 53

8.1-3 INITIATION 53

8.1-4 INVESTIGATION 54

8.1-5 MEDICAL EXECUTIVE COMMITTEE ACTION 55

8.1-6 DEFERRAL 56

8.1-7 PROCEDURAL RIGHTS 56

8.1-8 OTHER ACTION 56

8.2 SUMMARY SUSPENSION OF ALL OR PART OF A PRACTITIONER'S CLINICAL PRIVILEGES 57

8.2-1 CRITERIA FOR INITIATION 57

8.2-2 MEDICAL EXECUTIVE COMMITTEE ACTION; BOARD ACTION 57

8.2-3 PROCEDURAL RIGHTS 58

8.3 AUTOMATIC SUSPENSION 58

8.3-1 STATE AND FEDERAL REQUIREMENTS 58

8.3-2 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT 58

8.3-3 INSURANCE COVERAGE 59

8.3-7 NOTICE OF AUTOMATIC SUSPENSION; TRANSFER OF PATIENTS . 60

8.3-8 ENFORCEMENT 60

8.4 INTERVIEWS 60

Article IX: HEARINGS AND APPELLATE REVIEWS 61

9.1 PREAMBLE AND DEFINITIONS 61

9.1-1 EXHAUSTION OF REMEDIES 61

9.1-2 DEFINITIONS 61

9.2 GROUNDS FOR HEARING; NO HEARING RIGHTS 61

9.2-1 GROUNDS FOR HEARING 61

9.2-2 NO HEARING RIGHTS 62

9.3 REQUEST FOR A HEARING 63

9.3-1 NOTICE OF ACTION OR PROPOSED ACTION 63

9.3-2 REQUEST FOR HEARING 64

9.3-3 TIME AND PLACE FOR HEARING 64

9.3-4 NOTICE OF CHARGES 64

9.3-5 HEARING PANEL/HEARING OFFICER 64

9.3-6 FAILURE TO APPEAR 64

9.3-7 POSTPONEMENTS AND EXTENSIONS 65

9.4 HEARING PROCEDURE 65

9.4-1 PRE-HEARING PROCEDURE 65

9.4-2 REPRESENTATION 65

9.4-3 THE PRESIDING OFFICER 66

9.4-4 RECORD OF THE HEARING 66

9.4-5 RIGHTS OF THE PARTIES 66

9.4-6 MISCELLANEOUS RULES 67

9.4-7 BASIS OF DECISION 67

9.4-8 BURDEN OF GOING FORWARD AND BURDEN OF PROOF 67

9.4-9 ADJOURNMENT AND CONCLUSION 67

9.4-10 DECISION OF THE HEARING PANEL/HEARING OFFICER 68

9.5 APPEALS TO THE GOVERNING BOARD 68

9.5-1 TIME FOR APPEAL 68

9.5-2 GROUNDS FOR APPEAL 68

9.5-3 TIME, PLACE AND NOTICE 69

9.5-4 APPEAL BOARD 69

9.5-5 APPELLATE REVIEW PROCEDURE 69

9.5-6 DECISION 70

9.5-7 FURTHER REVIEW 70

9.5-8 RIGHT TO ONE HEARING 70

9.5-9 MANDATORY REPORTING 70

9.6 EXCEPTIONS TO HEARING RIGHTS 71

9.6-1 CLOSED STAFF OR EXCLUSIVE USE DEPARTMENTS 71

9.6-2 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES 71

Article X: OFFICERS 72

10.1 OFFICERS OF THE MEDICAL STAFF 72

10.1-1 IDENTIFICATION 72

10.1-2 QUALIFICATIONS 72

10.1-3 NOMINATIONS 73

10.1-4 ELECTION 73

10.1-5 TERM OF OFFICE; VACANCY; SUCCEEDING OFFICERS; ASSISTANTS 73

10.1-6 REMOVAL OF ELECTED OFFICERS 74

10.1-7 GROUNDS FOR REMOVAL 74

10.2 DUTIES OF OFFICERS 75

10.2-1 PRESIDENT 75

10.2-2 VICE PRESIDENT OF STAFF 76

10.2-3 SECRETARY-TREASURER 76

Article XI: CLINICAL DEPARTMENTS 78

11.1 ORGANIZATION OF DEPARTMENTS 78

11.2 DEPARTMENT CHAIRS 78

11.2-1 QUALIFICATIONS 78

11.2-2 SELECTION 78

11.2-3 TERM OF OFFICE 78

11.2-4 DUTIES 78

11.3 FUNCTIONS OF DEPARTMENT 79

11.4 ASSIGNMENT TO DEPARTMENTS 80

11.5 REMOVAL OF DEPARTMENT CHAIR 80

Article XII: COMMITTEES & GENERAL DUTIES 81

12.1 GENERAL 81

12.1-1 DESIGNATION 81

12.1-2 TERMS AND REMOVAL OF COMMITTEE MEMBERS 81

12.1-3 VACANCIES 82

12.1-4 CONDUCT AND RECORDS OF MEETINGS 82

12.1-5 VOTING 82

12.1-6 PRIVILEGE AND CONFIDENTIALITY 82

12.1-7 PARTICIPATION ON INTERDISCIPLINARY HOSPITAL COMMITTEES 82

12.2 MEDICAL EXECUTIVE COMMITTEE 82

12.2-1 COMPOSITION 82

12.2-2 DUTIES 82

12.2-3 MEETINGS 84

12.3 PROFESSIONAL PERFORMANCE COMMITTEE (PPC) 84

12.3-1 COMPOSITION 84

12.3-2 DUTIES 84

12.3-3 MEETINGS 84

12.4 PHARMACY AND THERAPEUTICS COMMITTEE 85

12.4-1 COMPOSITION 85

12.4-2 MEETINGS 85

12.5 EMERGENCY DEPARTMENT COMMITTEE 86

12.5-1 COMPOSITION 86

12.5-2 BASIC DUTIES 86

12.5-3 MEETINGS 86

12.6 INFECTION PREVENTION COMMITTEE 86

12.6-1 COMPOSITION 86

12.6-2 BASIC DUTIES 86

12.6-3 MEETINGS 87

12.7 BOARD QUALITY COMMITTEE (BQC) 87

12.7-1 COMPOSITION 87

12.7-2 BASIC DUTIES 87

12.7-3 MEETINGS 88

12.8 TISSUE CASE REVIEW 88

12.8-1 COMPOSITION 88

12.8-2 BASIC DUTIES 88

12.8-3 CASE REVIEWS 88

12.9 OTHER SPECIAL COMMITTEES & DUTIES 88

12.10 RELATIONSHIP OF STAFF MEMBER TO COMMITTEES 88

Article XIII: MEETINGS 90

13.1 MEETINGS 90

13.1-1 ANNUAL MEETING 90

13.1-2 REGULAR MEETINGS 90

13.1-3 AGENDA 90

13.1-4 SPECIAL MEETINGS 91

13.2 QUORUM 91

13.3 ACTION....91

13.4 MINUTES....91

13.5 ATTENDANCE REQUIREMENTS....92

13.5-1 GENERAL....92

13.5-2 SPECIAL ATTENDANCE FOR CASE PRESENTATION....92

13.6 COMMITTEE AND DEPARTMENT MEETINGS....93

13.6-1 REGULAR MEETINGS....93

13.6-2 SPECIAL MEETINGS....93

13.6-3 NOTICE OF MEETINGS....93

13.6-4 QUORUM....93

13.6-5 EX OFFICIO MEMBERS....94

13.6-6 ATTENDANCE....94

13.7 CONDUCT OF MEETINGS....94

Article XIV: CONFIDENTIALITY, IMMUNITY AND RELEASES....95

14.1 SPECIAL DEFINITIONS....95

14.2 AUTHORIZATIONS AND CONDITIONS....95

14.3 CONFIDENTIALITY OF INFORMATION....96

14.4 IMMUNITY FROM LIABILITY....96

14.4-1 FOR ACTION TAKEN....96

14.4-2 FOR PROVIDING INFORMATION....96

14.5 ACTIVITIES AND INFORMATION COVERED....96

14.6 RELEASES....97

Article XV: GENERAL PROVISIONS....98

15.1 RULES AND REGULATIONS....98

15.1-1 MEDICAL STAFF RULES AND REGULATIONS....98

15.1-2 DEPARTMENT RULES AND REGULATIONS 98
15.2 PROFESSIONAL LIABILITY INSURANCE 98
15.3 CONSTRUCTION OF TERMS AND HEADINGS 98
15.4 AUTHORITY TO ACT 98
15.5 ACCEPTANCE OF PRINCIPLES 99
15.6 DIVISION OF FEES 99
15.7 NOTICES 99
15.8 SECRET WRITTEN MAIL BALLOT 99
15.9 CONFLICTS 100
15.10 WAIVER 100
15.11 PROCEDURES NOT PERMITTED TO BE PERFORMED 100
15.12 TIME PERIODS 100
Article XVI: ADOPTION AND AMENDMENT OF BYLAWS 102
16.1-1 INITIATED BY MEDICAL STAFF 102
16.2 INITIATED BY GOVERNING BOARD 102
16.3 ACTION ON BYLAW CHANGE 103
16.4 APPROVAL 103
16.5 EXCLUSIVITY 103
VERSION I

REVISED

BYLAWS OF THE MEDICAL STAFF

WAVERLY HEALTH CENTER

Waverly, Iowa

PREAMBLE

WHEREAS, Waverly Health Center ("Hospital") is a tax-exempt hospital established and licensed under the laws of the State of Iowa and operated in compliance with applicable federal and state laws; and

WHEREAS, its purpose is to serve as the primary health resource for the community, providing health care, health maintenance, and health education services that appropriately anticipate and respond to the needs of the people residing in its service area; and

WHEREAS, the Board of Trustees ("Governing Board") has delegated responsibility and authority to the Medical Staff to assure the quality of medical and professional services provided by individuals with approved clinical and practice privileges, and the Medical Staff accepts accountability for those services, subject to the ultimate authority of the Governing Board; and

WHEREAS, it is recognized that the cooperative efforts of the Medical Staff, the Chief Executive Officer and the Governing Board are necessary to fulfill the foregoing responsibilities of the Medical Staff and the Hospital's obligations to its patients;

NOW, THEREFORE, the Practitioners practicing in this Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws, Rules and Regulations. Nothing in these Bylaws, Rules and Regulations is intended to create, or shall be deemed to create, a contract for employment or otherwise between the Hospital and any member of the Medical Staff or any other Practitioner who is allowed to provide care to patients of the Hospital pursuant to these Medical Staff Bylaws, Rules and Regulations.

DEFINITIONS

1. ALLIED PROFESSIONAL means an optometrist, chiropractor or certified health science provider in psychology, or other provider as approved from time to time by the Medical Staff.

2. CHIEF EXECUTIVE OFFICER or CEO means the person appointed by the Governing Board to act on its behalf in the overall management of the Hospital, or his or her authorized representative. The Administrator is the Chief Executive Officer (CEO) of the Hospital.

3. CHIEF OF STAFF means the chief elected officer of the Medical Staff. The President of the Medical Staff is the Chief of Staff.

4. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a Medical Staff member to render specific diagnostic, therapeutic, medical, surgical, dental, podiatric, or psychological services.

5. DEPARTMENT means that group of Practitioners who have clinical or practice privileges in one of the departments as designated by the Medical Staff.

6. DEPARTMENT CHAIR means the Medical Staff member duly appointed in accordance with these Bylaws to serve as the head of a recognized Hospital Department or Clinic.

7. GOVERNING BOARD means the Board of Trustees of the Hospital.

8. HOSPITAL means Waverly Health Center.

9. HOSPITAL-BASED SPECIALTY PRACTITIONER means a Practitioner, employed or engaged as an independent contractor by the Hospital on a full-time or part-time basis, whose duties include certain responsibilities which are both administrative and clinical in nature, such as a pathologist or radiologist. Clinical responsibilities, as used herein, are those responsibilities which require a Practitioner to exercise clinical judgment with respect to patient care and it includes the supervision of professional activities of other Practitioners or Hospital employees under his or her direction.

10. MEDICAL EXECUTIVE COMMITTEE or MEC means the Medical Executive Committee of the Medical Staff, unless specific reference is made to the Executive Committee of the Governing Board.

11. MEDICAL STAFF or STAFF means the formal organization of all Practitioners who are privileged to attend patients in the Hospital.

12. MEDICAL STAFF YEAR means January 1-December 31.

13. MIDLEVEL means an individual, other than a licensed physician, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Governing Board, the Medical Staff and the applicable State

Practice Acts, and who is qualified to render health services in the Hospital, under the supervision or direction, if required, of a Medical Staff member in good standing. Midlevels shall include: physician assistants, advanced registered nurse practitioners and certified registered nurse anesthetists.

14. NOTICE or NOTIFY means written notice given either by personal delivery or by regular United States mail, postage prepaid, except when otherwise provided in these Medical Staff Bylaws. Notice served by certified mail, return receipt requested, shall also be sufficient, whether required by these Medical Staff Bylaws or not.

15. PHYSICIAN means an individual with an M.D. or D.O. degree who is fully licensed to practice medicine.

16. PRACTITIONER means, unless otherwise expressly limited, any Physician, Midlevel, dentist, podiatrist, or Allied Professional who is applying for Medical Staff membership and/or Clinical Privileges, or who is a Medical Staff member and/or who exercises clinical privileges in this Hospital.

17. PREROGATIVE means a right granted to a Medical Staff member, by virtue of Staff category or otherwise, which is exercisable in accordance with the conditions imposed by these Bylaws and by other Hospital and Medical Staff rules, regulations, or policies. Prerogatives are voluntary.

ARTICLE I:
NAME

The name of this organization shall be The Medical Staff of Waverly Health Center.

ARTICLE II:
PURPOSES

2.1 PURPOSES

The purposes of this organization shall be:

(a) to assure that all patients admitted to or treated in any of the facilities, departments or services of the Hospital shall receive the appropriate level and quality of care, without regard to age, sex, race, nationality, creed, or sexual orientation.

(b) to assure a fully acceptable level of professional performance of all Practitioners authorized to practice in the Hospital, through the appropriate delineation of the clinical and practice privileges that each may exercise in the Hospital, and through ongoing review and evaluation of the care rendered by Practitioners in the Hospital;

(c) to provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Governing Board and Chief Executive Officer;

(d) to initiate and maintain rules and regulations for the Medical Staff to carry out its responsibility with respect to the professional work performed in the Hospital, pursuant to the authority delegated by the Governing Board in accordance with these Bylaws; and

(e) to provide education and maintain scientific standards that will lead to continuous advancement in professional knowledge and skills.

2.2 BYLAWS, RULES AND REGULATIONS

The purposes of the Medical Staff Bylaws, Rules and Regulations are:

(a) to define the organizational structure within which the Medical Staff shall operate in carrying out its responsibilities and pursuing its organizational purposes.

(b) to define the responsibilities and authority of individual Practitioners in their activities as officers or members of the Medical Staff.

(c) to establish rules, policies, and procedures governing the activities of Practitioners governed by these Bylaws in the Hospital.

(d) to establish simple, orderly, and effective communication between the Governing Board, Hospital administration, and the Medical Staff.

(e) to comply with and to create the means to comply with the requirements of licensing, accrediting, and regulatory bodies with jurisdiction over the Hospital.

ARTICLE III:
MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

3.1-1 IN GENERAL

Medical Staff membership and Clinical Privileges shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the Medical Staff shall confer on the member only such Clinical Privileges and Prerogatives as have been granted by the Governing Board in accordance with these Bylaws. No Practitioner shall admit patients or provide or order services to patients in the Hospital unless he or she is a member of the Medical Staff (or has been granted temporary privileges) and has been granted such Clinical Privileges to so admit or provide or order such services in accordance with the procedures set forth in these Bylaws.

3.1-2 ONGOING EVALUATION OF NEEDS

From time to time, the Governing Board shall evaluate the number, category, admissions, and hospital activities of medical staff appointees in various specialty areas, so that a proper number of individuals in each specialty is determined, maintained and revised as needed, in light of the professional requirements of the Hospital and the needs of the community.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 GENERAL QUALIFICATIONS

Practitioners shall be qualified for Medical Staff membership only if they:

(a) document their licensure, experience, background, training, ability, judgment, physical and mental health, and current clinical competency with sufficient adequacy to demonstrate that every patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the Hospital and Medical Staff, and that they are qualified to exercise clinical privileges within the Hospital.

(b) are determined, on the basis of documented references, to be of high moral character and to adhere to generally recognized standards of medical and professional ethics.

(c) are determined, on the basis of documented references, to work cooperatively with others in the Hospital setting, and to be willing to participate in and properly discharge Medical Staff responsibilities, and to commit to and regularly assist the Hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials.

(d) maintain their residence and medical practice closely enough to the Hospital to provide timely emergency on-call responses and continuous care to their hospitalized patients, as appropriate.

(e) participate equitably in the discharge of Medical Staff responsibilities, and comply with the Medical Staff Bylaws, Rules and Regulations and the other governing documents of the Hospital.

(f) at all times maintain in full force and effect for himself or herself a policy of professional liability insurance, in accordance with Section 15.2 hereof.

3.2-2 PARTICULAR QUALIFICATIONS

(a) Physicians. An applicant for physician staff membership on the Medical Staff must hold an M.D. or D.O. degree issued by a medical or osteopathic school approved by the Iowa Board of Medicine, a current, unrevoked, unrestricted and unsuspended license to practice medicine issued to him or her by the Iowa Board of Medicine, and be board certified or board eligible in the specialty in which privileges are requested, or in the case of Emergency Medicine privileges the physician may be board certified in either Family Medicine, Emergency Medicine or a combination of Internal Medicine/Pediatrics.

(b) Dentists. An applicant for dental staff membership on the Medical Staff must hold a D.D.S. degree issued by an accredited dental college approved by the Iowa Dental Board and a current, unrevoked, unrestricted and unsuspended license to practice dentistry issued to him or her by the Iowa Dental Board.

(c) Podiatrists. An applicant for podiatric staff membership on the Medical Staff must hold a D.P.M. degree issued by an accredited podiatry college approved by the Iowa Board of Podiatry and a current, unrevoked, unrestricted and unsuspended license to practice podiatry issued to him or her by the Iowa Board of Podiatry, and be board certified or board eligible in the specialty of podiatry.

(d) Psychologists. An applicant for psychology staff membership on the Medical Staff must hold a doctoral degree issued by an institution approved by the Iowa Board of Psychology, a current, unrevoked, unrestricted and unsuspended license to practice psychology issued to him or her by the Board of Psychology, and must be a certified health service provider in psychology pursuant to the Code of Iowa. The applicant shall be registered by the National Register of Health Service Providers in Psychology.

(e) Physician Assistants. A Physician Assistant who applies for membership on the Medical Staff must hold a physician assistant degree issued by an institution approved by the Iowa Board of Physician Assistants, and a current, unrevoked, unrestricted and unsuspended license to practice as a physician assistant issued to him or her by the Iowa Board of Physician Assistants, and be board certified or board eligible. Advanced Registered Nurse Practitioners and Certified Registered Nurse Anesthetists: An Advanced Registered Nurse Practitioner or Certified

Registered Nurse Anesthetists who applies for membership on the Medical Staff must hold an advanced nursing degree issued by an institution approved by the Iowa Board of Nursing and a current, unrevoked, unrestricted and unsuspended license to practice as an advanced registered nurse practitioner or certified registered nurse anesthetist, respectively, issued to him or her by the Iowa Board of Nursing, and be board certified or board eligible.

3.2-3 EFFECT OF OTHER AFFILIATIONS

No Practitioner shall be automatically entitled to Medical Staff membership, or to exercise any particular Clinical Privileges, merely because he or she holds a certain degree, is licensed to practice in Iowa or any other state, is a member of any professional organization, is certified by any clinical board, or had, or presently has, Staff membership or Clinical Privileges at this Hospital or at another health care facility.

3.3 NONDISCRIMINATION

No aspect of Medical Staff membership or particular Clinical Privileges shall be denied on the basis of sex, race, age, disability unrelated to the ability to provide appropriate patient care, creed, sexual orientation, color or national origin, or on the basis of any other criterion unrelated to the delivery of quality patient care in the Hospital setting, to professional qualifications, the Hospital's purposes, needs and capabilities, or community needs.

3.4 CONTRACTED AND HOSPITAL-BASED SPECIALTY PRACTITIONERS

A Practitioner who has entered into a contract with the Hospital, whether for employment, as an independent contractor or in a hospital-based specialty practice must be a Medical Staff member, achieving his or her status by the procedures provided in Articles III and IV of these Bylaws. The Medical Staff membership and Clinical Privileges of any hospital-based specialty Practitioner shall also be subject to the terms and conditions of his or her contract or agreement with the Hospital. The contract or agreement shall govern over these Medical Staff Bylaws as to all matters covered by the contract or agreement.

3.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Each member of the Medical Staff shall:

(a) provide his or her patients with care at the generally recognized professional level of quality and efficiency established by the Hospital under its medical review standards.

(b) retain responsibility within his or her area of professional competence for the continuous care and supervision of each patient in the Hospital for whom he or she is providing services, or arrange for a suitable alternative to assure such care and supervision.

(c) abide by the Medical Staff Bylaws and Rules and Regulations and by all other lawful standards, policies and rules of the Hospital.

(d) comply with all requirements set forth in the Medical Staff Bylaws and Rules and Regulations, including, but not limited to, those requiring attendance at meetings, maintenance of professional liability insurance, and refraining from unlawful fee-splitting. It shall be understood that a compensation arrangement involving payment by a group practice to a physician member of the group practice is not unlawful fee-splitting.

(e) discharge such personal, Medical Staff, Department, Committee and Hospital functions, including, but not limited to, peer review, patient care audit, utilization review, and emergency room coverage and back up functions, for which he or she is responsible by virtue of his or her Staff category assignment, appointment, election, or exercise of privileges, prerogatives, or other rights in the Hospital.

(f) prepare and complete in timely fashion the medical records and other required records for all patients he or she admits or in any way provides care to in the Hospital.

(g) A medical history and physical examination shall be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination shall be completed and documented in accordance with the hospital's policy titled "PC-P&P-1160 History and Physical for Surgery".

(g) aid in educational programs for Medical Staff members and Hospital personnel when requested and as appropriate.

(h) assist the Hospital in fulfilling its uncompensated or partially compensated patient care obligations within the areas of his or her professional competence and credentials.

(i) cooperate in any review of his or her or another's, credentials, qualification, or compliance with these Medical Staff Bylaws, Rules and Regulations, and refrain from directly or indirectly hindering any such review by threat, by withholding or falsifying information, or by other means.

(j) make appropriate use of the facilities and resources of the Hospital.

(k) agree that if any time, an adverse ruling is made with respect to the Practitioner's membership, Staff status, and/or Clinical Privileges, which affords the Practitioner Fair Hearing and Appellate Review rights hereunder, the Practitioner will exhaust all remedies afforded by these Bylaws and the Fair Hearing and Appellate Review Process before resorting to formal legal action.

(l) absolutely and unconditionally release from any and all liability the Hospital and all Hospital representatives for all actions performed in connection with providing, obtaining or reviewing information and evaluating or making recommendations or decisions concerning the Practitioner and the Practitioner's

credentials. The term "Hospital representative" includes the members of the Governing Board, all officers, employees, and agents of the Hospital, and all members and officers of the Medical Staff, its departments and committees, and any outside reviewers, who have responsibility for collecting, providing or evaluating information concerning the Practitioner's or Staff member's credentials or making recommendations or acting on any application for Medical Staff membership or Clinical Privileges.

(m) absolutely and unconditionally release from any liability all individuals and organizations who provide information to the Hospital and its representatives, including otherwise privileged or confidential information, relating to the applicant's ability, background, conduct, professional ethics, character, physical and mental health, emotional stability, and other matters relating to the applicant's qualifications for staff appointment and clinical privileges.

(n) authorize and consent to the Hospital, its officers, agents employees Medical Staff members and its representatives providing other hospitals, medical associations, licensing boards, the National Practitioner Data Bank and other health care organizations concerned with provider performance, conduct, and the quality, appropriateness, and efficiency of patient care, with any information or opinions related to such matters which the Hospital or any of its officers, agents, employees, Medical Staff members or representatives may have concerning the Practitioner, and absolutely and unconditionally release the Hospital and its officers, agents, employees, Medical Staff members and representatives from any and all liability for providing such information.

(o) agree to provide, upon request by the Medical Executive Committee, President of Staff or Hospital's Chief Executive Officer, access to and copies of the Practitioner's office charts and records relating to the treatment of patients who have been treated by the Practitioner in the Hospital or any related facility if deemed necessary for the review of the Practitioner's professional activities and current clinical competence.

(p) physicians and mid-level providers, subject to the supervisions of the physician, are designated and authorized qualified medical personnel to make a determination of presence or absence of an emergency medical condition.

3.6 DURATION OF APPOINTMENT

Initial appointments to the Active, Courtesy or Consulting categories of the Medical Staff shall complete a probationary period and during such probationary period, shall be considered a Provisional Staff member, in accordance with the provisions of Article IV. Except as otherwise recommended by the Medical Executive Committee and approved by the Governing Board, initial appointment shall extend to the end of the current

Medical Staff credentialing period. Subsequent reappointments shall be for a period of not more than two (2) full years.

3.7 LEAVE OF ABSENCE

3.7-1 LEAVE STATUS

A Medical Staff member may obtain a leave of absence from the Medical Staff by submitting written notice to the Medical Executive Committee and the CEO stating the approximate period of time of the leave, which may not exceed one (1) year. During the period of the leave, the member's Clinical Privileges, prerogatives, and responsibilities shall be suspended.

Any medical staff member who seeks to resume his or her hospital practice following a medical or personal leave shall be required to meet with the Medical Staff Executive Committee prior to resuming practice, for the purpose of ascertaining whether any restrictions on the individual's practice are indicated.

3.7-2 TERMINATION OF LEAVE

At least 30 days prior to the termination of the leave, or at any earlier time, the Medical Staff member shall request reinstatement of his or her privileges and prerogatives by submitting a written notice to that effect to the CEO and to the Medical Executive Committee. The Staff member shall submit a written summary of his or her relevant activities during the leave. The Medical Executive Committee shall recommend whether to approve the member's request for reinstatement of his or her privileges and prerogatives. Thereafter, the procedure set forth in Sections 6.3-5 through 6.3-8 shall be followed.

Failure, without good cause, to request reinstatement prior to the end of the one (1) year period or to provide a summary of activities as described above shall be deemed to be a voluntary resignation from the Medical Staff and shall result in termination of membership, privileges, and prerogatives. A practitioner whose membership, privileges, and prerogatives are so terminated shall be entitled to the procedures provided in Article IX, for the sole purpose of determining whether the failure was with or without good cause. A request for Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

ARTICLE IV:
CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The Medical Staff shall be divided into Active; Consulting; Courtesy; Honorary; Provisional, Allied, and Ancillary Professionals categories.

4.2 ACTIVE MEDICAL STAFF

4.2-1 QUALIFICATIONS

The Active Medical Staff shall consist of Practitioners who are Physicians or Midlevels who:

(a) meet the qualifications set forth in Section 3.2;

(b) regularly admit patients to, or otherwise regularly provide professional services for patients in the Hospital; At the invitation of MEC, regularly provide professional services for patients in the local community.

(c) maintain interest in the work of the Hospital and indicate a desire to assume the responsibility of contributing to the full, ongoing responsibilities of the Medical Staff; and

(d) have completed, unless specifically exempted, at least six (6) months of satisfactory performance as a Provisional Staff member.

4.2-2 PREROGATIVES

The prerogatives of an Active Medical Staff member shall be to:

(a) admit patients, or provide professional services for patients consistent with Clinical Privileges, unless otherwise provided in the Medical Staff Bylaws or Rules and Regulations.

(b) exercise such Clinical Privileges as are granted pursuant to Article VII.

(c) if a Physician, hold office in the Medical Staff and in the Department and committees of which he or she is a member and if elected, serve on the Executive Committee.

(d) serve on committees, unless otherwise provided in the Medical Staff Bylaws.

(e) vote for Medical Staff officers, on Bylaws amendments, and on all matters presented at general and special meetings of the Medical Staff and of the Department and committees of which he or she is a member, unless otherwise provided in the Medical Staff Bylaws.

(f) if a Midlevel: if trained in general medicine (i.e. family practice or internal medicine), they may (with approved privileges) participate in ER coverage. All work in the ER must be completed while a supervising physician is providing at minimum, phone back-up, per state regulation.

4.2-3 RESPONSIBILITIES

Each Active Medical Staff member shall:

(a) meet the basic responsibilities set forth in Section 3.5 and all responsibilities required by the Medical Staff Bylaws, Rules and Regulations, and other Medical Staff and Hospital policies and procedures in effect from time to time.

(b) actively participate in and regularly assist the Hospital in fulfilling its obligations related to patient care within the areas of his or her professional competence, including, but not limited to, emergency service and back up function, patient care audit, peer review, utilization review, quality evaluation and related monitoring activities required of the Medical Staff in supervising and reviewing initial appointees, Midlevels, Allied Professionals and others, and in discharging such other functions as may be required from time to time.

(c) satisfy the meeting attendance requirements for Active Medical Staff Members, set forth in Article XIII.

(d) if serving as a physician/provider with an "in person" requirement to be on call, these members shall reside in the community or within a reasonable distance from the Hospital.

(e) Any members admitting patients to the hospital must have another physician available for his/her patients if and when unavailable themselves.

4.3 COURTESY STAFF

4.3-1 QUALIFICATIONS

The Courtesy Staff shall consist of Practitioners who are Physicians, Midlevels, dentists or podiatrists who:

(a) meet the qualifications set forth in Section 3.2;

(b) admit, or otherwise provide professional services for patients in the Hospital on an occasional basis during each Medical Staff Year, or are specialists who provide direct patient care in the hospital and are not employed. The phrase "occasional basis" shall be determined from time to time by each applicable Department. An Active Medical Staff member may be placed in this category if he or she is not meeting the requirements of active membership; and

(c) have completed, unless specifically exempted, at least six (6) months of satisfactory performance as a Provisional Staff member.

4.3-2 PREROGATIVES

The prerogatives of a Courtesy Staff member shall be to:

(a) admit, or provide professional services for patients in the Hospital on an occasional basis during each Medical Staff Year, consistent with the limitations set forth in these Medical Staff Bylaws, Rules and Regulations. Courtesy Staff members may qualify for maximum Clinical Privileges within the scope of the Practitioner's credentials and the Hospital's procedural limitations. Members whose activity is or becomes more regular than "occasional" must apply and qualify for Active Staff status. The phrase "occasional basis" shall be determined from time to time by each applicable Department.

(b) exercise such Clinical Privileges as are granted to him or her pursuant to Article VII.

(c) attend meetings of the Medical Staff and the Department of which he or she is a member. A Courtesy Staff member may be requested to serve on standing or special committees, but may not hold office in the Medical Staff or in the Department of which he or she is a member.

(d) vote in committees on which he or she serves, but may not vote on any Medical Staff matter and is not eligible to hold office.

(e) if admitting patients to the Hospital, must have another physician available for his or her patients when he or she is unavailable.

(f) if emergency physicians under contract with the Hospital, may have Courtesy Staff membership if they are not Active Staff members, and if a Courtesy Staff member may only admit patients in cooperation with a Physician member who has admitting privileges, and once the patient is admitted, the patient immediately becomes the responsibility of such Physician with admitting privileges.

4.3-3 RESPONSIBILITIES

Each Courtesy member of the Medical Staff shall meet the basic responsibilities set forth in Section 3.6 and all responsibilities required by the Medical Staff Bylaws, Rules and Regulations, and other Medical Staff and Hospital policies and procedures in effect from time to time.

4.4 CONSULTING STAFF

4.4-1 QUALIFICATIONS

The Consulting Medical Staff shall consist of Practitioners who:

(a) meet the qualifications set forth in Section 3.2;

(b) are specialists or subspecialists, who generally provide consultation but do not provide patient care in the hospital and who may admit at the invitation of a Staff member with admitting privileges; and

(c) have completed, unless specifically exempted, at least six (6) months of satisfactory performance as a Provisional Staff member.

4.4-2 PREROGATIVES

A Consulting Staff member shall:

(a) admit, or provide professional services for, patients in the Hospital at the request of and along with a Physician member of the Active Medical Staff.

(b) exercise such Clinical Privileges as are granted to him or her pursuant to Article VII.

(c) At the invitation and approval of the Medical Executive Committee, may attend meetings of the Medical Staff, however cannot vote on any Medical Staff matter and is not eligible to hold office, but may serve on committees.

(d) if admitting patients to the Hospital, must have another physician available for his or her patients when he or she is unavailable.

4.4-3 RESPONSIBILITIES

Each Consulting member of the Medical Staff shall meet the basic responsibilities set forth in Section 3.6 and all responsibilities required by the Medical Staff Bylaws, Rules and Regulations, and other Medical Staff and Hospital policies and procedures in effect from time to time.

4.5 PROVISIONAL STAFF MEMBER

4.5-1 FOR INITIAL APPOINTMENTS

Except as otherwise recommended by the Medical Executive Committee and approved by the Governing Board, all applicants approved for membership in the Active, Courtesy and Consulting Staff category shall complete an initial probationary period of at least six (6) months during which time such Practitioner shall be a Provisional Staff Member. Each initial appointee shall be assigned to a Department where his or her performance will be observed and/or his or her charts reviewed by the Department Chair or his or her designee during the probationary period, to determine the initial appointee's eligibility for continued membership and privileges. His or her exercise of Clinical Privileges in any other Department shall also be subject to observation and/or chart review by that Department's chair or his or her designee for the probationary period required by that Department. An initial appointee shall remain on probationary status until the following

documents have been provided to the Medical Executive Committee, and the Medical Executive Committee votes to grant the Provisional Staff Member full privileges to the category of staff to which the Practitioner initially applied:

(a) a report, provided by the Medical Staff Coordinator and reviewed by the Professional Performance Council, that includes a combination of chart reviews, report of practice activity (including any negative trends), and co-worker and peer input (if available).

(b) as applicable, a signed statement from the provider's mentor that the initial appointee has satisfactorily demonstrated his or her ability to exercise the Clinical Privileges initially granted and their recommendation to continue membership and grant full privileges

4.5-2 FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

When recommended by the Medical Executive Committee, and approved by the Governing Board, Medical Staff members who change Medical Staff category or Department assignment, or who fail to meet the requirements of the Medical Staff attendance as outlined in Section 13.5, or who are initially granted additional privileges, shall complete a probationary period in accordance with the procedures outlined in this section for initial appointees.

4.5-3 TERM OF PROBATIONARY PERIOD

The probationary period for initial appointment for applicants to the Active, Courtesy or Consulting Staff or for a modification of membership status, or who fail to meet the requirements of the Medical Staff attendance as outlined in Section 13.5, or privileges shall be for a minimum period of 6 months and for a reasonable number of cases. At the discretion of the Medical Executive Committee, the probationary period may be waived in certain circumstances, such as when a provider has already been a privileged member of Medical Staff for a period of time under a different category. Each Department may establish a probationary term which establishes a longer period of time and/or a specific number of cases applicable to particular Clinical Privileges, whenever such requirements are appropriate in view of the Clinical Privileges which are involved. The period of probationary status may be extended in increments of not more than six months each, for a total probationary period of not more than 24 months. If an initial appointee fails within that period to complete the minimum number of cases and/or to furnish the certifications required in Section 4.6-1, his or her Medical Staff membership or particular Clinical Privileges, as applicable, shall be terminated. If a Medical Staff member requesting modification fails within that period to complete the minimum number of cases and/or furnish the certifications required in Section 4.6-1, the change in Medical Staff category or department assignment or the additional privileges, as applicable, shall be terminated. The Medical Executive Committee Chair Person shall give the initial appointee or Medical Staff member so affected, written notice that his or her Medical Staff membership and/or Clinical Privileges have been terminated because he or she

failed to satisfactorily complete the probationary requirements, and such Practitioner shall not have hearing rights under Article IX hereunder.

4.6 HONORARY STAFF

4.6-1 QUALIFICATIONS

The Honorary Staff shall consist of Practitioners recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital. An Honorary Staff designation is considered lifetime and no reappointment to the category is needed.

4.6-2 PREROGATIVES

Honorary Staff members are not eligible to admit patients to the Hospital or to exercise Clinical Privileges in the Hospital. They may, however, attend Medical Staff and Department meetings and any Medical Staff or Hospital education meetings. An Honorary Staff member may not vote on any Medical Staff matter, hold office in the Medical Staff or in the Department of which he or she is a member, or serve on committees.

Honorary Medical Staff members shall not lose membership by reason of loss of medical licensure due to failure to achieve satisfactory continuing medical education hours.

4.7 ALLIED PROFESSIONAL STAFF

4.7-1 QUALIFICATIONS

The Allied Professional Staff shall consist of Practitioners who are optometrists, chiropractors, certified health service providers in psychology, certified surgical assistants, or other providers as approved from time to time by the Medical Staff, who meet the qualifications set forth in Section 3.2.

4.7-2 PREROGATIVES

The prerogatives which may be extended to an Allied Professional may be further defined in the Medical Staff Rules or Regulations or an appendix thereto. Such prerogatives may include:

(a) responsibility for medical care of patients shall always be shared with a Physician in the Active or Courtesy Medical Staff and provision of specified patient care services, shall be under the supervision or direction of a Physician member of the Active or Courtesy Medical Staff, and consistent with the practice privileges granted to the Allied Professional and within the scope of the Allied Professional's licensure or certification.

(b) At the invitation and approval of the Medical Executive Committee, may attend meetings of the Medical Staff, however cannot vote on any Medical Staff matter and is not eligible to hold office, but may serve on committees.

(c) attendance at meetings of the Department to which he or she is assigned, as permitted by the Department, and attendance at Hospital educational programs in his or her field of practice.

4.7-3 RESPONSIBILITIES

Each Allied Professional shall:

(a) meet the basic responsibilities set forth in Section 3.6 and all responsibilities required by the Medical Staff Bylaws, Rules and Regulations, and other Medical Staff and Hospital policies and procedures in effect from time to time.

(b) retain appropriate responsibility within his or her area of professional competence for the care and supervision of each patient in the Hospital for whom he or she is providing services.

(c) participate, as requested and as appropriate, in patient care audit and other quality review, evaluation, and monitoring activities required of Allied Professionals in supervising initial appointees of his or her same occupation or profession, or of a lesser included occupation or profession, and in discharging such other functions as may be required from time to time.

(d) provide patient care in accordance with the requirements imposed by state and federal law on such Practitioner.

4.8 ANCILLARY PROFESSIONAL STAFF

4.8-1 QUALIFICATIONS

The Ancillary Professional staff shall consist of practitioners who are not employees of the hospital, who do not have any direct activity with hospital inpatients or outpatients, and who meet all of the qualifications set forth in section 3.2 except 3.2-1 (d). This may include practitioners who offer services in an independent visiting specialist setting on the Waverly Health Center campus, or practitioners where medical staff membership would support a productive collaborative relationship between the practitioner and Waverly Health Center.

4.8-2 PREROGATIVES

The prerogatives which may be extended to an ancillary professional may be further defined in the Medical Staff Rules or Regulations or an appendix thereto. Such prerogatives will not include privileges, and will include:

(a) independent responsibility for medical care of their patients in the visiting specialist clinic.

(b) At the invitation and approval of the Medical Executive Committee, may attend meetings of the Medical Staff, however cannot vote on any Medical Staff matter and is not eligible to hold office, but may serve on committees.

4.8-3 RESPONSIBILITIES

Each Ancillary Professional shall:

(a) meet the basic responsibilities set forth in Section 3.6 for initial appointment and subsequent reappointment(s), however will not be assigned to a probationary period.

(b) meet all responsibilities requested by the Medical Staff Bylaws, Rules and Regulations, and other Medical Staff and Hospital policies and procedures in effective from time to time.

(c) retain appropriate responsibility within his or her area of professional competence for the care and supervision of each patient in the visiting clinic for whom he or she is providing services.

(d) provide patient care in accordance with the requirements imposed by state and federal law on such Practitioner.

4.9 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these Bylaws, by the Medical Staff Rules and Regulations, or by other policies of the Hospital.

ARTICLE V:
MEDICAL AND SURGICAL ASSISTANTS; STUDENTS, RESIDENTS, AND INTERNS

5.1 MEDICAL AND SURGICAL ASSISTANTS

Medical and Surgical Assistants are persons who are not employees of the hospital, and who are not members of the Medical Staff, but who work from time to time in the Hospital and are employed by and responsible to members of the Medical Staff and who work under the Medical Staff member's direction and supervision. Supervising Medical Staff members shall show proof of liability insurance covering the medical or surgical assistant involved. All Medical and Surgical Assistants must request privileges to provide services in the Hospital under the direction and supervision of a Medical Staff member and shall do so on an appropriate form approved by the Governing Board. Applicants shall submit information pertaining to their educational background and their experience in the specialty in which the privileges are requested, providing dates, places and descriptions of duties performed and by whom supervised. Medical and Surgical Assistants shall not be afforded hearing or other procedural rights under these Bylaws.

STUDENTS, RESIDENTS AND INTERNS

Students who are concurrently enrolled in an accredited allopathic or osteopathic medical, dental, podiatry, or doctoral psychology school or residency or internship program or an accredited physician assistant training or similar program shall not hold membership on the medical staff and shall not *normally* be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by Waverly Health Center. Interns, residents and students will be supervised by a Waverly Health Center credentialed and privileged physician or podiatrist. Students may also be supervised by a Waverly Health Center credentialed and privileged midlevel.

If the need arises, residents or fellows in training may apply for privileges to observe, assess and/or treat patients in the Hospital under the direction and supervision of a physician or podiatrist who is member of the Medical Staff. Such students, residents and interns may exercise only those specific clinical privileges as are granted to them, and shall not be afforded hearing or other procedural rights under these Bylaws.

The Education Department must communicate periodically with the MEC about the performance of its students, residents, and interns; patient safety issues; and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

ARTICLE VI:
PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

6.1 GENERAL PROCEDURE

6.1-1 PRE-APPLICATION REQUIREMENT

Only those Practitioners who meet the basic criteria for medical staff membership and privileges set forth in these Medical Staff Bylaws shall be eligible to apply for medical staff appointment. Practitioners requesting applications for appointment will be sent a letter by the Medical Staff Office outlining the basic criteria for eligibility and requiring the Practitioner to provide proof that he or she meets those criteria. If the criteria are met, the Practitioner will receive an application form and a summary of the application, hearing and appeal provisions of the Medical Staff Bylaws. If the criteria are not met, the Practitioner will be so notified. The procedural due process rights set forth in Article IX of these Bylaws shall not be available to Practitioners who are determined to be ineligible to apply for appointment because they do not meet the basic criteria.

6.1-2 GROUNDS FOR NOT PROVIDING APPLICATION FORM

No application for appointment shall be provided to a Practitioner, nor shall an application be accepted from a prospective applicant, if the Chief Executive Officer or Governing Board determines based on information from a pre-application questionnaire or any other source that:

(a) the Hospital does not have the ability to provide adequate facilities or services for the applicant or the patients to be treated by the prospective applicant;

(b) the prospective applicant has interests or activities that are inconsistent with the needs, mission, operations and/or plans of the Hospital and the community it serves, including any medical staff development plan;

(c) the Hospital has contracted with an individual or group to provide the clinical services sought by the prospective applicant on an exclusive basis, and the prospective applicant will not be associated with the individual or group contracted with;

(d) the prospective applicant has been excluded from participation in Medicare or Medicaid;

(e) the prospective applicant does not meet the requirements relating to licensure and registration, professional liability insurance, board certification, or reapplication after adverse decision or resignation while under investigation or to avoid an investigation;

(f) the prospective applicant is not a type of Practitioner approved by the Governing Board to provide patient care services in the Hospital;

(g) the prospective applicant does not have a valid unrestricted state license, or is subject to any form of counseling, monitoring, supervision, educational requirement or any other ongoing review, condition, requirement or restriction of any kind;

(h) the prospective applicant has been convicted of a felony or convicted of a misdemeanor related to the applicant's fitness to practice medicine or other profession, as applicable; or

(i) the prospective applicant has provided materially false or misleading information on any pre-application questionnaire or in connection with any pre-application review process.

No application for reappointment shall be provided to a Practitioner who is currently a member of the Medical Staff or holds Clinical Privileges if the Practitioner has not provided requested information or documents or not responded to requests for comments concerning peer review or quality improvement matters or the Practitioner's qualification for Medical Staff membership and privileges, provided the Staff member has been notified in writing of the requested information and has not responded within thirty (30) calendar days.

The applicant or prospective applicant shall be advised of the information relied on as grounds for not providing an application and the applicant or prospective applicant shall have a reasonable opportunity to submit information or evidence that the information relied on is not accurate.

No individual shall be entitled to a hearing or any other procedural rights as a result of a refusal by the Hospital to provide the individual an application form for initial appointment or reappointment.

6.1-3 NATURE OF MEDICAL STAFF CONSIDERATION

The Medical Staff, through the Medical Executive Committee, shall consider each application for appointment or reappointment to the Medical Staff, and for Clinical Privileges, utilizing the resources of the CEO and his or her staff to investigate and validate the contents of each application, before adopting and transmitting its recommendations to the Governing Board.

The Medical Staff, through the Medical Executive Committee, shall also perform the same function in connection with any individual who has applied only for temporary privileges, or who otherwise seeks to exercise privileges or to provide specified services in any Hospital service.

6.2 APPLICATION FOR APPOINTMENT

6.2-1 CONTENT

All applications for appointment to the Medical Staff shall be in writing or via an electronic method, and shall be signed by the applicant and submitted on a form approved by the Governing Board, with all information provided or an explanation of why the information is not provided, and accompanied by the required processing fee. The application shall require detailed information including, but not limited to:

(a) detailed information concerning the applicant's education, institutional positions held, professional qualifications, competency, Iowa licensure, current DEA registration, continuing medical education related to the Clinical Privileges to be exercised by the applicant, a valid picture ID issued by a state of federal agency (e.g., driver's license or passport);

(b) the names of at least three persons who hold the same professional license as does the applicant, who can provide adequate references based on their current knowledge of the applicant's professional qualifications, professional competency and ethical character;

(c) whether any action, including any investigation, has ever been undertaken, whether it is still pending or complete, which involves denial, revocation, suspension, reduction, limitation, probation, non-renewal, or voluntary relinquishment by resignation or expiration (including relinquishment that was requested or bargained for) of the applicant's membership status and/or clinical privileges and/or prerogatives at any other hospital or institution; membership or fellowship in any local, state, regional, national, or international professional organization; license to practice any profession in any jurisdiction; drug enforcement administration or other controlled substances registration; specialty board certification; and/or professional school faculty position or membership;

(d) pursuant to Section 15.2 of these Medical Staff Bylaws, evidence of the applicant's professional liability insurance coverage with a company licensed or approved to do business in Iowa, together with information regarding any professional liability claims, complaints, or causes of action that have been lodged against him or her within the past five (5) years and the status or outcome of such matters;

(e) as to any pending administrative agency or court cases, or administrative agency decisions or court judgments in which the applicant is alleged to have violated, or was found guilty of violating, any criminal law (excluding minor traffic violations) or is alleged to be liable, or was found liable, for any injury caused by the applicant's negligent or willful act or omission in rendering services within the past five (5) years;

(f) details of any prior or pending government agency proceeding or litigation challenging or sanctioning applicant's patient admission, treatment, discharge,

charging, collection, or utilization practices, including, but not limited to, Medicare and Medicaid fraud and abuse proceedings and convictions, within the past five (5) years;

(g) information concerning the condition of the applicant's physical and mental health, to assure the applicant's present ability to carry out the responsibilities and prerogatives of the Medical Staff membership category and to perform the clinical privileges applied for with reasonable skill and without exposing the applicant or others to significant health or safety risks;

(h) certification of the applicant's agreement to terms and conditions set forth in Section 6.2-2 regarding the effect of the application; and

(i) an acknowledgment that the applicant has received or has been given access to the Medical Staff Bylaws and Rules and Regulations, and that he or she agrees to be bound by the terms thereof, as they may be amended from time to time, if he or she is granted membership or clinical privileges, and to be bound by the terms thereof, without regard to whether or not he or she is granted membership and/or clinical privileges in all matters relating to consideration of this application.

The applicant shall also identify the Medical Staff category, clinical Department and Clinical Privileges for which the applicant wishes to be considered.

6.2-2 EFFECT OF APPLICATION

By applying for appointment or reappointment to the Medical Staff, each applicant thereby makes the following representations:

(a) signifies his or her willingness to appear for interviews in regard to his or her application;

(b) authorizes the Hospital and its representatives or its designees to consult with members of medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his or her competence, character and ethical qualifications, and authorizes such persons to provide all such information;

(c) consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his or her professional qualifications, ability and willingness to work harmoniously with others, moral and ethical qualifications for membership, and physical, mental, and professional competence to carry out the clinical privileges he or she requests, and directs individuals who have custody of such records and documents to permit inspection and/or copying;

(d) certifies that he or she will report any changes in the information submitted on the application form, which may subsequently occur, to the CEO;

(e) releases from any liability, to the fullest extent permitted by law, all individuals and organizations providing information to the Hospital concerning the applicant and all Hospital representatives for their acts performed in connection with evaluating the applicant and his or her credentials;

(f) that, to the best of his or her knowledge, he or she is not at risk of offset or other disallowance of future payments due under Medicare, Medicaid or other federal or state health programs, or other third party payment programs for professional services to be rendered, because of current or past billing, coding or documentation errors, or disputes with a professional review organization. The Practitioner agrees to make all reasonable attempts to ensure that records are coded appropriately for services rendered, and agrees to cooperate with any compliance program or compliance audit that the Hospital may undertake to ensure that billing and coding for services rendered is conducted in full compliance with all laws and regulations;

(g) that neither the Practitioner nor his or her employees, contractors or agents, nor any member of the Practitioner's immediate family, has or will have a "financial relationship" (as that term is defined in Section 1877 of the Social Security Act) with Hospital which fails to qualify for an exception to the prohibition contained therein against certain referrals of designated health services. For purposes of this provision, "immediate family" is defined to mean spouse, natural or adoptive parent, child or sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, daughter-in-law, son-in-law, brother-in-law, sister-in-law, grandparent, grandchild and spouse of a grandparent or grandchild. The Practitioner shall immediately report to the Hospital's CEO, or his or her designee, any known or suspected financial relationship to permit analysis to determine compliance with this provision; and

(h) that neither the Practitioner nor any of his or her employees, contractors or agents, nor any member of the Practitioner's household or immediate family, who now has or has had a direct or indirect ownership of 5% or more in the Practitioner's professional practice, has ever been: assessed civil monetary penalties under the Social Security Act; debarred, suspended, or excluded from participating in either Medicare or Medicaid; sanctioned under Medicare or Medicaid for reasons bearing on professional competence or professional performance; has ever had an ownership interest in any other organization which has ever had a civil monetary penalty under Medicare or Medicaid; or has ever been convicted or pled guilty or nolo contendere to any criminal violation which could cause a disqualification under applicable state law. The Practitioner agrees to immediately notify the Hospital of any threatened, proposed, or actual exclusion of the Practitioner from participation in any governmental health care program.

6.3 PROCESSING THE APPLICATION

6.3-1 APPLICANT'S BURDEN

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing accurate and adequate information for a proper evaluation of his or her experience, background, training, demonstrated ability, physical and mental health, and all other qualifications specified in the Medical Staff Bylaws and Rules and Regulations, and of his or her compliance with standards and criteria set forth in the Medical Staff Bylaws and Rules and Regulations, and for resolving any reasonable doubts about these matters and satisfying requests for additional information. The applicant's failure to sustain this burden shall be deemed a voluntary withdrawal of the application. This burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate.

Failure to complete and update the application form, failure to provide requested information, or providing incomplete, false or misleading information shall in and of itself constitute a basis for denial or revocation of Medical Staff appointment or reappointment.

6.3-2 VERIFICATION OF INFORMATION

The applicant shall deliver a completed application to the Chief Executive Officer who shall refer the application to the President of the Medical Staff who shall provide it to the Medical Executive Committee for evaluation.

Within the time period of receiving the completed application and the Medical Executive Committee decision on that application, the Medical Executive Committee, or designee, shall collect or verify the references, licensure, and other qualification evidence submitted. In accordance with Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1988 (HCQIA), as amended, the Hospital shall query the National Practitioner Data Bank. In addition, the Hospital shall check the Department of Health and Human Services Office of Inspector General's excluded provider lists to ensure the applicant has not been excluded from participation in Medicare, Medicaid or other federal health care programs.

The Medical Executive Committee shall, at a minimum, obtain written verification of credentialing information at the primary source; written verification of an unrestricted medical license; written verification that the applicant graduated from an accredited medical school; written information from hospital chiefs and directors of residency programs, fellowships and other relevant training programs; written report from National Practitioner Data Bank query; assurance that investigation of an applicant whose authority to prescribe controlled substances is being challenged; verification of malpractice claims history directly with the insurance carrier; verification of Board Certification status directly with the Certifying Board if required for the particular practitioner; written verification of recertification for Specialists whose Boards have time limited certificates; and assurance that all hospitals with which a Practitioner has had

privileges, have been contacted. The combined information should be sufficient to investigate the character, qualifications, and standing of the applicant to the satisfaction of the Executive Committee.

The Medical Executive Committee shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. The Medical Executive Committee may ask the applicant to appear for an interview or request further documentation.

An applicant whose application is not completed within six months after it was received by the Chief Executive Officer shall be deemed to have voluntarily withdrawn his or her application from consideration for Staff membership. Such an applicant's application may, thereafter, be reconsidered only if all information therein which may change over time, including, but not limited to, Hospital reports and personal references, has been resubmitted.

6.3-3 MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION

Within 120 days after receipt of the completed application, and supporting documentation, the Medical Executive Committee shall review the application, the supporting documentation, and such other relevant information as may be available, and, upon voting on the application in accordance with the voting provisions for the Medical Executive Committee under these Bylaws, shall make a written recommendation regarding the application and forward such report to the CEO, for transmittal to the Governing Board. The Medical Executive Committee's written recommendations shall be prepared in accordance with Section 6.3-4 and shall be based upon the factors in Section 6.3-5. The Medical Executive Committee may also defer action on the application pursuant to Section 6.3-6(a).

6.3-4 APPOINTMENT RECOMMENDATION

The Medical Executive Committee recommendations shall be submitted in the form prescribed by the Medical Executive Committee, and shall be considered to be peer review protected information. Each recommendation shall specify whether Medical Staff appointment is recommended, and if so, the membership category, department affiliation, and Clinical Privileges to be granted and any special conditions to be attached to the appointment. The reasons for each recommendation shall be stated, and supported by reference to the completed application and all other documentation which was considered, all of which shall be transmitted with the recommendation. The recommendation shall state the applicant's qualifications, other hospital affiliations and the Medical Executive Committee's opinion in regard to the applicant's moral character, professional competence, and compatibility with the needs of the Hospital.

6.3-5 BASIS FOR APPOINTMENT

Each recommendation concerning an applicant for Medical Staff membership and Clinical Privileges shall be based upon whether the applicant meets the qualifications specified in Section 3.2, can carry out the responsibilities specified in Section 3.5, and

meets all of the standard requirements set forth in all sections of these Bylaws and in the Medical Staff Rules and Regulations. Specifically, recommendations shall also be based upon the Practitioner's compliance with legal requirements applicable to the practice of his or her profession and other hospitals' Medical Staff Bylaws, Rules and Regulations, and policies; rendition of services to his or her patients; any physical or mental impairment which might interfere with the applicant's ability to practice medicine with reasonable skill and safety; his or her provision of accurate and adequate information to allow the Medical Staff to evaluate his or her competency and qualifications; information obtained from the National Practitioner Data Bank and other data sources as appropriate; and the representations set forth in this Section 6.2-2.

6.3-6 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

(a) Interviews, Further Documentation, Deferral: Action by the Medical Executive Committee to interview the applicant, seek further documentation, or defer the application for further consideration must be followed up within 60 days of the Medical Staff Executive Committee receiving the completed application with a subsequent recommendation for appointment with specified Clinical Privileges, or for denial of the request for Medical Staff membership.

(b) Favorable Recommendation: When the Medical Executive Committee's recommendation is favorable to the applicant, the CEO shall promptly forward it, together with all supporting documentation, to the Governing Board. For the purpose of this Section 6.3-6(b), "all supporting documentation" includes the application form and its accompanying information and the reports and recommendations of the Department Chair and the Medical Executive Committee.

(c) Adverse Recommendation: When the Medical Executive Committee's recommendation is adverse to the applicant, the CEO shall give the applicant written notice of the adverse recommendation and if the adverse decision is based on the applicant's competence and/or conduct, the CEO shall inform the applicant of the applicant's right to request a hearing in the manner specified in Section 9.3-2, and that the applicant shall be entitled to the procedural rights as provided in Article IX. For the purposes of this Section 6.3-6(c), an "adverse recommendation" by the Medical Executive Committee is as defined in Section 9.2. The Governing Board shall be informed of, but not take action on, the pending adverse recommendation until the applicant has exhausted or waived his or her procedural rights set forth in Article IX.

6.3-7 ACTION BY THE GOVERNING BOARD

(a) On Favorable Medical Executive Committee Recommendation: The Governing Board shall, within ninety (90) days of the Medical Executive Committee receiving the completed application in whole or in part, adopt or reject a Medical Executive Committee recommendation which is favorable to the applicant or refer the recommendation back to the Medical Executive Committee for further interviews, documentation, or consideration stating the reasons for such referral

back and setting a time limit within which a subsequent recommendation shall be made.

(1) if the recommendation of the Governing Board is one of those set forth in Section 9.2-1, the CEO shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3-2; and the applicant shall be entitled to the procedural rights as provided in Article IX before any final adverse action is taken.

(2) If the recommendation of the Governing Board is favorable, it shall become effective as the final decision of the Governing Board.

(b) Without Benefit of Medical Executive Committee Recommendation: If the Governing Board does not receive a Medical Executive Committee recommendation within the time period specified in Section 6.3-3, it may, after notifying the Medical Executive Committee, take action on its own initiative. However, if the Governing Board takes action on its own initiatives as set forth hereunder, the Governing Board shall seek and consider the advice of a Physician regarding a recommendation as to the applicant, after such Physician has reviewed the application.

(1) If the Governing Board's recommendation is favorable, it shall become effective as the final decision of the Governing Board.

(2) If the Governing Board's recommendation is one of those set forth in Section 9.2-1, the CEO shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3-2; and the applicant shall be entitled to the procedural rights as provided in Article IX before any final adverse action is taken.

(c) After Procedural Rights: In the case of an adverse Medical Executive Committee recommendation which gives rise to a hearing pursuant to Section 6.3-6(c) or 6.4-3, or an adverse Governing Board recommendation gives rise to a hearing pursuant to Section 6.3-7(a) or (b), the Governing Board shall take final action in the matter only after the applicant has exhausted or has waived his or her procedural rights as provided in Article IX. Action thus taken shall be the conclusive decision of the Governing Board, except that the Governing Board may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Governing Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Governing Board shall make a final decision.

6.3-8 NOTICE OF FINAL DECISION

(a) Notice of the Governing Board's final decision shall be given, through the CEO, to the Medical Executive Committee, and the applicant.

(b) A decision and notice to appoint shall include: (1) the staff category to which the applicant is appointed; (2) the service to which he or she is assigned; (3) the Clinical Privileges he or she may exercise; and (4) any special conditions attached to the appointment.

6.3-9 REAPPLICATION AFTER ADVERSE DECISION DENYING APPLICATION, ADVERSE CORRECTIVE ACTION DECISION, OR RESIGNATION IN LIEU OF MEDICAL DISCIPLINARY ACTION

(1) An applicant who (a) has received a final adverse decision regarding appointment, reappointment or clinical privileges or (b) has withdrawn his or her application or request for membership or privileges following an adverse recommendation by the Medical Executive Committee or Governing Board or in order to avoid investigation; (2) a former medical staff member who has (a) received a final adverse decision resulting in termination of medical staff membership and clinical privileges or (b) resigned from the medical staff following the issuance of a medical staff or Governing Board recommendation adverse to the member's medical staff membership or privileges; or (3) a medical staff member who has received a final adverse decision resulting in (a) termination or restriction of his or her clinical privileges or (b) denial of his or her request for additional clinical privileges, shall not be eligible to reapply for medical staff membership and/or clinical privileges affected by the previous action for a period of at least two years from the date the adverse decision became final, the date the application or request was withdrawn, or the date the former medical staff member's resignation became effective, whichever is applicable.

A decision shall be considered to be adverse, for medical disciplinary reasons, only if it is based on the type of occurrences which might give rise to corrective action and not if it is based upon reasons that do not directly pertain to medical or ethical conduct. Actions which are not considered adverse include actions based on a failure to maintain a practice in the area, which can be cured by a move, or to maintain professional liability insurance, which can be cured by securing such insurance. Further, for the purpose of this section, an adverse decision shall include appellate review, and other quasi-judicial proceedings conducted by the Hospital bearing on the decision and all judicial proceedings bearing upon the decision which are filed and served after the completion of the Hospital proceedings described in this section.

After the two year period, the former applicant, former medical staff member, or medical staff member may request an application for medical staff membership and/or privileges, which shall be processed as an initial application. The former applicant, former medical staff member or medical staff member, shall also furnish evidence that the basis for the earlier adverse recommendation or action no longer exists and/or reasonable rehabilitation in those areas which form the basis for the previous adverse

recommendation or action, whichever is applicable. In addition, such applications shall not be processed unless the applicant or member submits satisfactory evidence to the Medical Executive Committee that he or she has complied with all of the specific requirements any such adverse decision may have included, such as completion of training or proctoring conditions. The Medical Executive Committee's decision as to whether satisfactory evidence has been submitted shall be final, subject only to further review by the Governing Board within 45 days after the Medical Executive Committee decision was rendered.

6.4 REAPPOINTMENTS

6.4-1 APPLICATION FOR REAPPOINTMENT; SCHEDULE FOR REVIEW

At least one hundred and twenty (120) days prior to the expiration of each Practitioner's current Staff appointment, the Chief Executive Officer shall provide a reappointment application to the Staff member.

At least ninety (90) days prior to the expiration date of his or her Staff appointment, each Practitioner shall submit to the Chief Executive Officer a completed reappointment application form. The reappointment application shall be in writing or via an electronic method, on a form prescribed by the Medical Staff and approved by the Governing Board, and it shall require detailed information concerning the changes in the applicant's qualifications since his or her last review. Specifically, the reappointment application form shall request all of the information and certifications requested in the appointment application form, as described in Section 6.2, except for 6.2-1(b) and information which cannot change over time, such as information regarding the member's premedical and medical education, date of birth, and so forth. The form shall also require information as to whether the applicant requests any change in his or her Staff status and/or in his or her Clinical Privileges, including any reduction, deletion or addition to privileges. Requests for additional privileges must be supported by the type and nature of evidence which would be necessary for such privilege to be granted in an initial application for same. Waverly Health Center reserves the right to require 6.2-1(b) in the absence of clinical activity data.

6.4-2 VERIFICATION OF INFORMATION

The Medical Executive Committee or designee shall, in timely fashion, seek to collect or verify the additional information made available on each reappointment application form and to collect any other materials or information deemed pertinent, and shall query the National Practitioner Data Bank. The Medical Executive Committee shall also determine whether the applicant's name is on the OIG's list of providers excluded from Medicare, Medicaid or other federal health care programs. If the applicant is to provide additional information or a specific release/authorization to allow the Hospital representatives to obtain additional information, the notice to him or her shall state the same, and must include a request for the specific information or release/authorization and the time period within which the applicant must respond. Failure without good cause to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application.

6.4-3 MEDICAL EXECUTIVE COMMITTEE ACTION/ BOARD ACTION

The Medical Executive Committee shall review the completed application and supporting documents, and all other relevant information available to it, and shall forward to the Governing Board, through the CEO, its favorable recommendations, prepared in accordance with Section 6.4-4.

When the Executive Committee recommends adverse action, as defined in Section 9.2, either in respect to reappointment or Clinical Privileges, the CEO shall give the applicant written notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3-2, and the applicant shall be entitled to the procedural rights as provided in Article IX. The Governing Board shall be informed of, but not take action on, the pending recommendation until the applicant has exhausted or waived his or her procedural rights.

Thereafter, the procedures specified in Sections 6.3-7 (Action by the Governing Board) and 6.3-8 (Notice of Final Decision) shall be followed.

Without Benefit of Medical Executive Committee Recommendation: If the Governing Board does not receive a Medical Executive Committee recommendation within sixty days of receiving the completed reapplication, it may, after notifying the Medical Executive Committee, take action on its own initiative. However, if the Governing Board takes action on its own initiatives as set forth hereunder, the Governing Board shall seek and consider the advice of a Physician regarding a recommendation as to the applicant, after such Physician has reviewed the application.

(1) If the Governing Board's recommendation is favorable, it shall become effective as the final decision of the Governing Board.

(2) If the Governing Board's recommendation is one of those set forth in Section 9.2-1, the CEO shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3-2; and the applicant shall be entitled to the procedural rights as provided in Article IX before any final adverse action is taken. Thereafter, the procedures specified in Sections 6.3-7 (Action by the Governing Board) and 6.3-8 (Notice of Final Decision) shall be followed.

6.4-4 REAPPOINTMENT RECOMMENDATION

The Medical Executive Committee recommendation shall be written and shall be submitted in the form prescribed by the Medical Executive Committee. Each recommendation shall specify whether the applicant's appointment should be renewed, renewed with modified membership category, service affiliation, and/or Clinical Privileges, or terminated. Where non-reappointment, denial of requested privileges, a reduction in status, or a change in Clinical Privileges is recommended, the reason for such recommendation shall be stated and documented.

6.4-5 LOW/NO ACTIVITY

If, at the end of a two-year reappointment period, the practitioner has had low to no activity at the Hospital, the Medical Executive Committee, upon approval from the Governing Board, may deem this a voluntary resignation from the Medical Staff. The Medical Executive Committee will refer to criteria established regarding low/no volume as outlined in MS-P&P-1254 Low-No Provider Activity. Practitioners who are deemed to have voluntarily resigned due to lack of activity shall be entitled to apply for Medical Staff as an initial applicant. Practitioners who are deemed to have voluntarily resigned due to lack of activity shall not be entitled to hearing rights as outlined in Section 9 unless the resignation results in a report to any state or national agency because it is based on the physician's competence or professional conduct.

6.4-5 BASIS FOR REAPPOINTMENT

Each recommendation concerning the reappointment of a Practitioner and the Clinical Privileges to be granted upon reappointment shall be based upon whether such individual has met the qualifications specified in Section 3.2, carried out the responsibilities specified in Section 3.5, as applicable, and met all of the standards and requirements set forth in all sections of these Medical Staff Bylaws and in the Medical Staff Rules and Regulations. Specifically, recommendations shall also be based upon the Practitioner's compliance with legal requirements applicable to the practice of his or her profession, with the Medical Staff Bylaws and Rules and Regulations and Hospital policies; rendition of services to his or her patients; any physical or mental impairment which might interfere with the applicant's ability to provide medical care with reasonable skill and safety; his or her provision of accurate and adequate information to allow the Medical Staff to evaluate his or her competency and qualifications; information obtained from the National Practitioner Data Bank and other data sources as appropriate; and the representations set forth in Section 6.2-2.

6.4-6 FAILURE TO FILE REAPPOINTMENT APPLICATION

If a Practitioner fails to file an application for reappointment within the time period, and completed as required by Section 6.4-1, he or she shall be deemed to have voluntarily resigned his or her membership in the Medical Staff, and as such, shall not be entitled to the procedural rights provided in Article IX.

6.4-7 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement after a leave of absence or after termination for failure to meet the requirements for meeting attendance, among other things, shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges and prerogatives. A member, whose membership is automatically terminated, shall be entitled to the procedural rights provided in Article IX for the sole purpose of determining whether or not the failure to request reinstatement was unintentional or excusable. A subsequent request for medical

staff membership received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

ARTICLE VII:
CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES; REDETERMINATION OF PRIVILEGES

(a) Every Practitioner providing clinical services at this Hospital by virtue of Medical Staff membership or otherwise, shall be entitled to exercise only those clinical privileges specifically granted to him or her by the Governing Board, except as otherwise provided in Sections 7.4, 7.5 and 7.6 of this Article VII.

(b) Redetermination of Clinical Privileges will be made at least every two (2) years, and the increase or curtailment of same shall be based upon the direct observation of the care provided and by a review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care and quality assessment and improvement activities. This review of privileges occurs simultaneously with the reappointment process and includes the same criteria required for reappointment. In the event there is evidence that a Medical Staff member's patient care is not up to quality standards or there are complaints about care, the clinical privileges and the Medical Staff status can be reviewed by the Medical Staff Executive Committee at any time. A change in privileges may occur after a member of the Medical Staff Executive Committee submits a request for change to the Staff member's Clinical Privileges, reasons for the change, description of applicable continuing medical education activities, other appropriate documentation, and then receiving approval in accordance with the process set forth in Section 6.4 for reappointment.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2-1 REQUESTS

Every application for appointment and reappointment must contain a request for the specific clinical or professional practice privileges desired by the applicant. Requests from an applicant for privileges, or from members for modification of privileges, must be supported by documentation of the requisite training, experience, qualifications and competency to exercise such privileges.

7.2-2 BASIS FOR PRIVILEGE DELINEATION

Requests for privileges shall be evaluated on the basis of the applicant's education, training, experience, physical and mental health, and demonstrated ability and judgment. The elements to be considered in making determinations regarding privileges, whether in connection with periodic reappointment or otherwise, shall include education, training, observed clinical performance and judgment, performance of a sufficient number of procedures each year to develop and maintain the practitioner's skills and knowledge, and the documented results of the patient care audit and other quality review, evaluation, and monitoring activities required by these and the Hospital Bylaws to be conducted at the Hospital. Privileges determinations shall also take into account pertinent information

concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises Clinical Privileges.

7.2-3 PROCEDURE

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article VI.

7.3 SPECIAL CONDITIONS

7.3-1 APPLICABLE TO DENTAL AND PODIATRIC PRIVILEGES AS WELL AS TO CHIROPRACTORS AND OPTOMETRISTS

Privileges granted to dentists, oral surgeons, podiatrists, chiropractors, & optometrists shall be based on their training, experience, demonstrated competence and judgment. A doctor of medicine or osteopathy in the Active category of the Medical Staff is responsible for the care of each patient with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization and that is not specifically within the scope of practice as defined by the Medical Staff and permitted by Iowa law.

Licensed chiropractors are legally authorized to perform the services of a chiropractor but only with respect to treatment by means of manipulation of the spine to correct a subluxation demonstrated by x-ray to exist as interpreted by Hospital radiologist.

Anesthesia administered during surgical procedures by a dentist or podiatrist must be under the oversight of the Chief of Surgery, or his/her designee.

7.3-2 APPLICABLE TO MIDLEVELS AND ALLIED PROFESSIONALS

(a) For each category of Midlevel, the Governing Board shall identify the mode of practice in the Hospital setting (i.e., whether dependent or independent and the role of the supervising or collaborative physician, if any) and the Clinical Privileges of the Midlevels.

(b) Certified Registered Nurse Anesthetists are not required to be supervised in the Hospital.

(c) Midlevels shall not have admitting privileges at the Hospital.

(d) Allied Professionals shall not have admitting privileges at the Hospital.

(e) Midlevels and Allied Professionals shall be afforded only those Clinical Privileges that are within their scope of practice as determined by state law.

(f) Midlevels and Allied Professionals shall be supervised in accordance with state law.

(g) Hospital outpatient services pertaining to their scope of treatment may be requested by Allied Professionals.

7.4 TEMPORARY PRIVILEGES

7.4-1 CONDITIONS

Temporary privileges may be granted only when:

(a) the Practitioner has submitted a written or electronic application for appointment or a written request for temporary privileges and the information available reasonably supports a favorable determination regarding the requesting Practitioner's licensure, qualifications, ability, and judgment to exercise the privileges requested;

(b) the Practitioner has satisfied the requirement regarding professional liability insurance set forth in Section 15.2;

(c) the Practitioner makes the representations set forth in Section 6.2-2 of these Medical Staff Bylaws;

(d) an inquiry to the National Practitioner Data Bank yields no materially adverse information; and

(e) the Practitioner acknowledges in writing that he or she has received, or has been given access to, the Medical Staff Bylaws and Rules and Regulations, and that he or she agrees to be bound by the terms thereof in all matters relating to his or her temporary privileges.

Special requirements of consultation, supervision and reporting may also be imposed by the Chair of the Department to which the Practitioner is assigned.

7.4-2 CIRCUMSTANCES

Temporary privileges are granted by the CEO or his or her designee upon the written recommendation of the President of the Medical Staff or his or her designee to an appropriately licensed Practitioner of documented competence, subject to all of the conditions set forth in Section 7.4-1 above, in the following circumstances:

(a) Pendency of Application:

After acceptance of the prescribed application by the Hospital, if a specific patient need has been identified, a Practitioner may be granted temporary Clinical Privileges for an initial period of thirty (30) days or until the next meeting of the Governing Board, with subsequent renewals subject to reasonable progress shown

on the pending application, with a maximum period of 120 days of being eligible for temporary privileges. In order to be granted temporary privileges hereunder, the Medical Staff Executive Committee must verify at least the following: Current licensure; Relevant training and experience; Current competence; Ability to perform the privileges requested; A query and evaluation of the NPDB information; A complete application; No current or previously successful challenge to licensure or registration; No subjection to involuntary termination of a Medical Staff membership at another organization; and No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges at the Hospital or any other organization.

(b) Care of Specific Patients; Locum Tenens:

Specific temporary clinical privileges may be granted to a Practitioner who is not an applicant for Medical Staff membership for the care of one or more specific patients or to cover the service of one of more members of the Medical Staff for a maximum time period of 120 days, after which time, if the Practitioner wishes to continue to provide care or cover services at the Hospital, the Practitioner shall be required to apply for membership on the Medical Staff under the procedures set forth in these Bylaws. In order to be granted temporary privileges hereunder, the Medical Staff Executive Committee must verify at least the following: Current licensure; Current competence; Ability to perform the privileges requested; A query and evaluation of the NPDB information; A complete application; No current or previously successful challenge to licensure or registration; No subjection to involuntary termination of a Medical Staff membership at another organization; and No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges at the Hospital or any other organization.

7.4-3 TERMINATION

Temporary Privileges automatically terminate at the end of the 120 day limit, as applicable. On the discovery of any information, or the occurrence of any event, of a nature which raises a question about a Practitioner's professional qualifications, ability to exercise any or all of the temporary privileges granted, or compliance with any Bylaws, rules, regulations, or special requirements, the CEO, the CEO's designee, or the President of the Medical Staff may, after consultation with the applicable Department Chair or his or her designee may, terminate any or all of such Practitioner's temporary privileges. However, where it is determined that the life or well-being of a patient would be endangered by continued treatment by the Practitioner, the termination may be effected by any person entitled to impose a summary suspension pursuant to Article VIII of these Medical Staff Bylaws, and the same shall be immediately effective. In such event, the Chair of the Department or, in his or her absence, the Chair of the Executive Committee, shall assign a member of the Medical Staff to assume responsibility for the care of the terminated Practitioner's patients then in the Hospital. The wishes of the patient shall be considered, where feasible, in assigning a substitute practitioner.

7.4-4 RIGHTS OF THE PRACTITIONER

A Practitioner shall not be entitled to the procedural rights afforded by Article IX because his or her request for temporary privileges is refused or because all or any portion of his or her temporary privileges are terminated or suspended.

7.5 EMERGENCY PRIVILEGES

For the purposes of this section, an "emergency" is defined as a condition in which a patient is in imminent danger of serious or permanent harm or death, and any delay in administering treatment would add to that danger. In the case of emergency, any practitioner, to the degree permitted by his or her license and regardless of Department or Medical Staff status or Clinical Privileges, shall be permitted and assisted to do everything possible to save the patient from such danger. When an emergency situation no longer exists, the emergency privileges will automatically terminate, and such Practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are not requested or are denied, the patient shall be assigned to an appropriate member of the Medical Staff by the President of Staff or his or her designee.

7.6 DISASTER PRIVILEGES

During a disaster, when the Emergency Management Plan has been activated, the Chief Executive Officer or President of the Medical Staff or his or her designee may grant disaster privileges upon presentation or verification of a current medical license with primary source verification and a valid government issued photo identification. In addition, one of the following must be presented:

(a) a current hospital photo identification card or a second type of government issued photo identification.

(b) 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 Professional (ESAR-VHP), or other recognized state of federal response organizations or groups..

(c) identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity.

(d) presentation by current Hospital or Medical Staff member with personal knowledge regarding the Practitioner's identity.

The individual to whom disaster privileges have been granted will be given a temporary ID badge and will work under direction of an active Medical Staff member.

Verification of credentials of an individual granted disaster privileges will begin as soon as the immediate situation is under control. The process to be followed will be identical to that of Temporary Privileges in Section 7.4 of these Bylaws.

7.7 TELEMEDICINE PRIVILEGES

Telemedicine is the provision of clinical services to patients by Members from a distance via electronic communications. It encompasses the overall delivery of healthcare to the patient through the practice of patient assessment, diagnosis, treatment, consultation, transfer and interpretation of medical data and patient education all via a telemedicine link (for example, audio, video, and data telecommunications as may be utilized by distant-site Members). The Governing Body shall have final approval of the clinical services to be provided through telemedicine by a Member after considering the recommendations of the MEC.

b. For purposes of these bylaws, the definition of an "Originating Site" is one where the patient is located at the time the service is provided. The definition of "Distant Site" is one where the Member providing the professional service is located. This may include a Distant Site hospital or Distant Site telemedicine entity as defined and set forth in the CMS Conditions of Participation, The Joint Commission (TJC) Accreditation Standards and any other applicable accreditation standards or laws governing telemedicine privileges.

c. In processing a request for Telemedicine Privileges at the Hospital and the Distant Site, the MEC may rely on the credentialing and privileging decisions from the Distant Site to make its own credentialing and privileging recommendation to the Governing Body if the Hospital has a written agreement with the Distant Site and the distant site, complies with CMS and TJC Standards and is accredited by TJC. The Governing Body shall then consider the MEC's recommendation in making a final credentialing and privileging decision for the Hospital.

d. Waverly Health Center will comply with TJC standards and other regulatory requirements for credentialing and granting telemedicine privileges to practitioners.

ARTICLE VIII:
CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1-1 CRITERIA FOR INITIATION

Corrective action may be initiated against a Practitioner with Clinical Privileges whenever the Practitioner engages in conduct, makes statements, or exhibits demeanor either within or outside of the Hospital that meets any of the following:

(a) is detrimental to patient safety or to the delivery of quality patient care within the Hospital;

(b) is disruptive to Hospital operations such that the delivery of quality or efficient patient care is likely to be adversely affected;

(c) is contrary to the Medical Staff Bylaws, associated manuals, rules and regulations, or medical staff or Hospital policies;

(d) is below applicable professional standards of behavior or clinical management; or

(e) constitutes fraud or abuse, or the same results in an investigation, corrective action or the imposition of sanctions by any governmental authority, against such Practitioner.

Corrective action, including an investigation may be initiated by any individual or body as set forth in Section 8.1-3 below, upon the complaint, request or suggestion of any person. Such acts, statements, demeanor or conduct by a Hospital employee who is not a member of the Medical Staff should be brought to the attention of the CEO for the initiation of appropriate action.

8.1-2 PEER REVIEW CONFIDENTIALITY

Corrective action and hearing and appellate review proceedings, as set forth in these Medical Staff Bylaws, shall be considered peer review committee proceedings entitled to the privilege and confidentiality protection of federal and state laws. The written request for investigation or corrective action, as well as complaint files, investigation files, reports, and other investigative information prepared for the purpose of the peer review matter at issue shall be considered peer review records that are privileged and confidential in the hands of the peer review committee and the Hospital, and shall be released only as required or permitted by law.

8.1-3 INITIATION

Proposed corrective action, including a request for an investigation, must be initiated by (1) the President of Staff; (2) the Medical Executive Committee; (3) the Chief Executive Officer; or (4) the Governing Board, each on its own initiative or after a written request

has been submitted to such individual or body by any person which identifies the specific activities or conduct which are alleged to constitute the grounds for proposing an investigation or specific corrective action. In order to initiate a corrective action investigation, the individual or body listed above must submit a written request for corrective action to the President of the Medical Staff (or to the Vice President if the President is the subject of the request) which specifies the basis for such request.

When the corrective action is initiated by the President of Staff or by the Medical Executive Committee, the President of Staff shall promptly notify the CEO and Governing Board of all proposals for corrective action so initiated. The President of Staff shall continue to keep the CEO and the Governing Board fully informed of all action taken in conjunction therewith.

8.1-4 INVESTIGATION

Upon receipt of the written request initiating corrective action, the President of Staff or designee shall take action on the request by directing that an investigation be undertaken by an investigating officer or investigating committee. The President of Staff may conduct that investigation himself or herself or may assign this task to an appropriately charged officer, or to a standing or ad hoc Medical Staff committee. The investigating officer or committee members shall not include partners, associates, or relatives of the affected Practitioner or Practitioners who are in direct economic competition with the affected Practitioner. The investigating officer or committee shall have available the full resources of the Medical Staff to aid in its investigation, as well as the authority to use outside consultants as necessary. The investigating officer or group may require a physical or mental evaluation of the affected Practitioner by a physician satisfactory to the investigating officer or committee and shall require that the results of the evaluation be made available for the investigating officer or committee's consideration. No such investigative process shall be deemed to be a "hearing" as described in Article IX.

An external peer review consultant should be considered when: (a) litigation seems likely; (b) The Hospital is faced with ambiguous or conflicting recommendations from medical staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances, consideration may be given by the Medical Executive Committee or the Governing Board to retain an objective external reviewer; (c) There is no one on the Medical Staff with expertise in the subject under review, or when the only Medical Staff members with appropriate expertise are direct competitors, partners or associates of the Practitioner under review.

During the investigative process, the Practitioner against whom corrective action has been requested shall have an opportunity for an interview with the investigating officer or committee before the investigating officer or committee makes its report to the Medical Executive Committee. Such interview shall be in accordance with Section 8.4. At such interview, the Practitioner shall be informed of the general nature of the charges against him or her, and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Medical Staff Bylaws with respect to hearings shall apply thereto. A

summary record of the interview shall be made and included in the report to the Medical Executive Committee.

If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall forward a written report of the investigation to the Medical Executive Committee, as soon as is practicable under the circumstances, but in any event within fifteen (15) days after the assignment to investigate has been made, unless extended for good cause shown. The Medical Executive Committee may at any time within its discretion, and shall at the request of the Governing Board, terminate the investigative process and proceed with action as provided in Section 8.1-5 below.

8.1-5 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as is practicable after the conclusion of the investigative process, if any, but in any event within thirty (30) days after the Medical Executive Committee receives or generates a report of the investigation, unless deferred pursuant to Section 8.1-6, the Medical Executive Committee shall act thereon. Such action may include, without limitation, the following recommendations to the Governing Board:

(a) No corrective action be taken and, if the Medical Executive Committee determines that no credible evidence existed for the complaint, the removal of any complaint-related information from the member's file.

(b) Rejection or modification of the proposed corrective action.

(c) Letters of admonition, censure, reprimand, or warning, be issued, although nothing herein shall be deemed to preclude the CEO, the President of Staff, or Department Chair from issuing informal written or oral warnings outside the corrective action mechanism. If such letters are issued, the affected member may make a written response that shall be placed in the member's file.

(d) Terms of probation or special limitations be imposed on continued membership or the exercise of privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring.

(e) Reduction or revocation of clinical privileges.

(f) Suspension of clinical privileges until completion of specific conditions or requirements.

(g) Reduction of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care.

(h) Suspension of Medical Staff membership until completion of specific conditions or requirements.

(i) Revocation of Medical Staff membership.

(j) Other actions appropriate to the facts which prompted the investigation.

Nothing set forth herein shall inhibit the Medical Executive Committee from implementing summary suspension at any time, in the exercise of its discretion pursuant to Section 8.2.

8.1-6 DEFERRAL

If additional time is needed to complete the investigative process, the Medical Executive Committee may defer action on the request for a reasonable period of time, and it shall so notify the affected Practitioner. A subsequent recommendation for any one or more of the actions provided in Section 8.1-5, Paragraphs (a) through (j) above must be made within the time specified by the Medical Executive Committee, and if no such time is specified, then within fifteen (15) days of the deferral.

8.1-7 PROCEDURAL RIGHTS

Any recommendation by the Medical Executive Committee pursuant to Section 8.1-5 which constitutes grounds for a hearing as set forth in Section 9.2 shall entitle the affected Practitioner to the procedural rights provided in Article IX of these Bylaws. In such cases, the CEO shall give the Practitioner written notice of the adverse recommendation and of his or her right to request a hearing in the manner specified in Section 9.3-2.

8.1-8 OTHER ACTION

(a) If the Medical Executive Committee's recommended action is to recommend no corrective action, such recommendation, together with such supporting documentation as may be required by the Governing Board, shall be transmitted to the Governing Board. Thereafter, the procedure to be followed shall be the same as that provided for applicants in Sections 6.3-7 (Action by the Governing Board) and 6.3-8 (Notice of Final Decision), as applicable.

(b) If the Medical Executive Committee's recommended action is an admonition, censure, reprimand, or warning to a Practitioner (or other action which does not give rise to a hearing in Article IX), it shall, at the Practitioner's request, grant him or her an interview as provided in Section 8.4. Following the interview, if one is requested, if the Medical Executive Committee's final recommendation to the Governing Board is an admonition, censure, reprimand, or warning, such recommendation, together with such supporting documentation as may be required by the Governing Board, shall be transmitted to the Governing Board. Thereafter, the procedure to be followed shall be the same as that provided for applicants in Sections 6.3-7 (Action by the Governing Board) and 6.3-8 (Notice of Final Decision), as applicable, and additionally, notice of the final recommendation shall be given to the Governing Board, CEO, Medical Executive Committee, the Chair of each Department concerned, and the Practitioner.

(c) Should the Governing Board determine that the Medical Executive Committee has failed to act in timely fashion on the proposed corrective action, the Governing Board, after notifying the Medical Executive Committee, may take action on its own initiative. If such action is favorable to the Practitioner, or constitutes an admonition, reprimand or warning to the Practitioner, or other action which does not give rise to a hearing in Article IX, it shall become effective as the final decision of the Governing Board. If such action is one of those set forth in Section 9.2 which gives rise to a hearing, the CEO shall give the Practitioner written notice of the adverse recommendation and of his or her right to request a hearing in the manner specified in Section 9.3-2 and his or her rights shall be as provided in Article IX.

8.2 SUMMARY SUSPENSION OF ALL OR PART OF A PRACTITIONER'S CLINICAL PRIVILEGES

8.2-1 CRITERIA FOR INITIATION

Whenever a Practitioner's conduct requires immediate action to be taken to reduce a substantial likelihood of imminent impairment of the health or safety of any patient, prospective patient, employee or other person present in the Hospital, any person or body authorized to initiate a corrective action investigation pursuant to Section 8.1-3 hereof shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the Clinical Privileges of the Practitioner, and such summary suspension shall become effective immediately upon imposition. The person or body responsible therefore shall promptly give oral or written notice of the suspension to the Practitioner, Governing Board, Medical Executive Committee, and CEO. The notice of the suspension given to the Medical Executive Committee shall constitute a request for corrective action and the applicable procedures set forth in Section 8.1 shall be followed. In the event of any such suspension, the Practitioner's patients whose treatment by such Practitioner is terminated by the summary suspension shall be assigned to another practitioner by the Department Chair or by the President of Staff. The wishes of the patient shall be considered, where possible, in choosing a substitute practitioner.

8.2-2 MEDICAL EXECUTIVE COMMITTEE ACTION; BOARD ACTION

A Practitioner whose clinical privileges have been summarily suspended may request an interview with the Medical Executive Committee, in accordance with Section 8.4. The interview shall be convened as soon as reasonably possible under all of the circumstances, ordinarily within 15 calendar days of the date of the suspension. The Medical Executive Committee must thereafter, as soon as practicable and within 20 calendar days after such summary suspension has been imposed, recommend modification, continuance or termination of the terms of the summary suspension order, and written notice of its decision shall be given to the Practitioner, the Governing Board, and the CEO. Unless the recommendation is to terminate the summary suspension, the Medical Executive Committee's recommendation shall be considered a professional review action giving rise to the procedural rights set out in Article IX. If the recommendation of the Medical Executive Committee is to terminate the summary

suspension, such recommendation, together with such supporting documentation as may be required by the Governing Board, shall be transmitted to the Governing Board. Thereafter, the procedure to be followed shall be the same as that provided for applicants in Sections 6.3-7 (Action by the Governing Board) and 6.3-8 (Notice of Final Decision), as applicable, and additionally, notice of the final recommendation shall be given to the Governing Board, CEO, Medical Executive Committee, the Chair of each Department concerned, and the Practitioner.

8.2-3 PROCEDURAL RIGHTS

Unless the Medical Executive Committee recommends termination of the summary suspension, such summary suspension shall remain in effect during the pendency and completion of the corrective action process and of the hearing and appellate review process if initiated. The Practitioner shall be entitled to the procedural rights afforded by Article IX once the summary suspension lasts more than twenty (20) calendar days or once the Medical Executive Committee has made a recommendation that is considered to be a professional review action under 8.2-2, whichever is earlier.

8.3 AUTOMATIC SUSPENSION

8.3-1 STATE AND FEDERAL REQUIREMENTS

A Practitioner may be automatically immediately suspended in the event any practitioner:

(a) fails to maintain a current, active, unrestricted appropriate State license;

(b) is excluded from participation in Medicare or Medicaid; or

(c) fails to maintain a current, active DEA and CSA certification (if required for the practitioner's specialty).

In the event of such immediate automatic suspension, the practitioner shall be notified of the suspension and the basis of the suspension by regular and certified mail, and given ten (10) calendar days to produce clear and convincing evidence that the facts relied on in taking such automatic action are not correct. If the Hospital does not receive such evidence from the Staff member within ten (10) calendar days, the individual shall be deemed to be no longer qualified for Medical Staff membership and his or her Clinical Privileges shall automatically terminate, in which event the Practitioner shall not be entitled to a hearing or the procedural rights set forth in Article IX.

8.3-2 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A Practitioner who fails, without good cause, to appear and satisfy the requirements of Section 13.5-2, shall automatically be suspended from exercising all, or such portion of his or her Clinical Privileges as may be suspended, in accordance with the provisions of said Section 13.5-2. A Practitioner who fails, without good cause, to appear and satisfy the requirements of Section 13.5-2 within two (2) months of the implementation of such automatic suspension, and who has been given an opportunity to so appear after the

implementation of such automatic suspension, shall be deemed to have voluntarily resigned the Practitioner's Medical Staff membership.

8.3-3 INSURANCE COVERAGE

Practitioners shall maintain the requisite insurance coverage as required by Section 15.2 of these Bylaws. Practitioners who fail to maintain the requisite insurance coverage shall be automatically suspended as of the date such insurance coverage lapsed, and shall remain suspended until such time as the Practitioner regains the requisite insurance coverage. A failure to regain the requisite insurance coverage within two (2) months from the date that the automatic suspension became effective pursuant to this section shall be deemed to be a voluntary resignation of the Practitioner's Medical Staff membership.

8.3-4 MEDICAL RECORDS

Medical records shall be completed according to policy and procedure, Documentation Requirements for Medical Records RC-P&P-1175 . For failure to complete medical records within the time limits established, a Practitioner's Clinical Privileges (except with respect to his or her patients already in the Hospital) and his or her rights to admit patients and to provide any other professional services may be automatically suspended upon the expiration of fifteen (15) days after he or she is given written notice of delinquency, unless such failure is excused by the President of Staff or his or her designee upon a showing of good cause. If suspended, the Clinical Privileges shall remain so suspended until all delinquent medical records are completed; A subsequent failure to complete the medical records within two (2) months after the date a suspension became effective pursuant to this section shall be deemed to be a voluntary resignation of the Practitioner's Medical Staff membership.

8.3-5 PROCEDURAL RIGHTS

Practitioners whose Clinical Privileges are automatically suspended and/or who have resigned their Medical Staff membership pursuant to the provisions of 8.3-2, 8.3-3 and 8.3-4 shall be entitled to the procedural rights set forth in Article IX, but the hearing and appeal shall be limited solely to a factual determination of whether good cause existed for the Practitioner's failure to appear and satisfy the requirements of 13.5-2, whether the requisite continuous insurance coverage was maintained, or the medical records were timely completed or good cause was shown for their failure to be timely completed, as applicable.

8.3-6 FAILURE TO BECOME BOARD CERTIFIED OR FAILURE TO MAINTAIN BOARD CERTIFICATION

A Practitioner who fails to become Board certified or maintain Board certification in compliance with these Bylaws or with Medical Staff credentialing policies will be deemed to have immediately and voluntarily relinquished his or her medical staff appointment and Clinical Privileges.

8.3-7 NOTICE OF AUTOMATIC SUSPENSION; TRANSFER OF PATIENTS

Whenever a Practitioner's privileges are automatically suspended in whole or in part, notice of such suspension shall be given to the Practitioner, the Medical Executive Committee, the CEO and the Governing Board. Giving of such notice shall not, however, be required in order for the automatic suspension to become effective. In the event of any such suspension, the Practitioner's patients, whose treatment by such Practitioner is terminated by the automatic suspension, shall be assigned to another Practitioner by the President of Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner.

8.3-8 ENFORCEMENT

It shall be the mutual duty of the President of the Medical Staff, the CEO, and the Governing Board to cooperate fully in enforcing all automatic suspensions.

8.4 INTERVIEWS

Interviews shall neither constitute, nor be deemed, a "hearing", as described in Article IX; shall be preliminary in nature; and shall not be conducted according to the procedural rules applicable with respect to hearings. The Medical Executive Committee shall be required, at the Practitioner's request, to grant him or her an interview only when so specified in this Article VIII. In all other cases and when the Medical Executive Committee or the Governing Board has before it an adverse recommendation, as defined in Section 9.2, it may, but shall not be required to, furnish the Practitioner an interview. In the event an interview is granted, the Practitioner shall be informed of the general nature of the circumstances leading to such recommendation and may present information relevant thereto. A record of the matters discussed and findings resulting from such interview shall be made.

ARTICLE IX:
HEARINGS AND APPELLATE REVIEWS

9.1 PREAMBLE AND DEFINITIONS

9.1-1 EXHAUSTION OF REMEDIES

If an adverse ruling is made with respect to a Practitioner's Staff membership, Staff status or Clinical Privileges at any time, regardless of whether he or she is an applicant for Medical Staff membership or a Medical Staff member, he or she must exhaust the intra-organizational remedies afforded by these Bylaws before resorting to formal legal action challenging the decision, the procedures used to arrive at it, or asserting any claim against the Hospital or participants in the decision process.

9.1-2 DEFINITIONS

Except as otherwise provided in these Bylaws, the following definitions shall apply under this Article:

(a) "Body whose decision prompted the hearing" refers to the Medical Executive Committee or authorized officers, members, or committees of the Medical Staff who took the action or rendered the decision which resulted in a hearing being requested, and refers to the Governing Board in all cases where the Governing Board or authorized officers, directors or committees of the Governing Board took the action or rendered the decision which resulted in a hearing being requested.

(b) "Notice" refers to a written communication delivered personally to the required addressee or sent by United States Postal Service, first-class postage prepaid, certified or registered mail, return receipt requested, addressed to the required addressee at his or her or its address as it appears in the records of the Hospital.

(c) "Petitioner" refers to the practitioner who has requested a hearing pursuant to Section 9.3 of these Bylaws.

(d) "Date of Receipt" of any notice or other communication shall be deemed to be the date such notice or communication was delivered personally to the required addressee or, if delivered by mail, such notice or communication shall be deemed received 48 hours after being deposited, postage prepaid, in the United States mail in compliance with paragraph (b) of this Section 9.1-2.

9.2 GROUNDS FOR HEARING; NO HEARING RIGHTS

9.2-1 GROUNDS FOR HEARING

Hearings are limited to those circumstances where action is being taken based on the professional competence and/or professional conduct of the Practitioner. Any one or more of the following actions or recommended actions shall constitute grounds for a

hearing if based on professional competence and/or conduct, unless otherwise required by these Bylaws:

(a) denial of Medical Staff membership.

(b) denial of requested advancement in Staff membership status.

(c) denial of Staff reappointment.

(d) demotion to lower Staff category or membership status.

(e) suspension of Staff membership until completion of specific conditions or requirements.

(f) summary suspension of Staff membership or Clinical Privileges during the pendency of corrective action and hearings and appeals procedures.

(g) expulsion from Staff membership.

(h) denial of requested privileges (not including temporary privileges).

(i) reduction in privileges.

(j) suspension of Clinical Privileges until completion of specific conditions or requirements.

(k) termination of privileges (not including temporary privileges).

(l) requirement of consultation.

(m) any professional review action which is reportable to the National Practitioner Databank.

Recommendation of any of these actions shall constitute an "adverse recommendation" for the purposes of these Bylaws.

9.2-2 NO HEARING RIGHTS

No Practitioner shall be entitled to a hearing as a result of any action which is recommended or taken which is not reportable to the state or the National Practitioner Data Ban, including, but not limited to, the following:

(a) letters of warning, reprimand, or admonition.

(b) imposition of monitoring, proctoring, review or consultation requirements.

(c) requiring provision of information or documents, such as office records, or notice of events or actions.

(d) imposition of educational or training requirements.

(e) placement on probationary or other conditional status.

(f) appointment or reappointment for less than two (2) years.

(g) failure to place a practitioner on any on-call or interpretation roster, or removal of any practitioner from any such roster.

(h) continuation of provisional appointment.

(i) the refusal of the Board of Trustees to grant a request for a waiver or extension of time regarding the Board certificate requirements set forth herein.

(j) termination of medical staff membership and/or clinical privileges as a result of matters which are not related to the practitioner's professional competence or conduct such as, but not limited to:

(1) failure to pay dues or assessments,

(2) failure to meet any objective requirement imposed on all staff members that specific numbers of procedures be performed to maintain or demonstrate clinical competence,

(3) the Hospital elects to enter into an exclusive contract for the provision of certain services;

(4) failure to adhere to Medical Staff attendance policies; or

(5) failure to adhere to the Hospital's medical chart delinquency policy.

If any action is taken which does not entitle the Practitioner to a hearing, the Practitioner shall be offered the opportunity to submit a written statement or any information which the practitioner wishes to be included in the practitioner's peer review records along with the documentation regarding the action taken.

9.3 REQUEST FOR A HEARING

9.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases where the body which, under these Bylaws, has the authority to, and pursuant to that authority, has recommended or taken any of the actions constituting grounds for hearing as set forth in Section 9.2 of this Article, said body shall, through the CEO, give the affected Practitioner notice of its recommendation, decision or action and notice of his or her right to request a hearing pursuant to Section 9.3-2, below.

9.3-2 REQUEST FOR HEARING

The Practitioner shall have thirty (30) days following the date of receipt of notice of such action to request a hearing. Said request shall be effected by notice to the President of Staff with a copy to the CEO. In the event the Practitioner does not request a hearing within the time and in the manner herein above set forth, he or she shall be deemed to have accepted the recommendation, decision or action involved and it shall thereupon become the final action of the Medical Staff. Such final recommendation shall be considered by the Governing Board within forty-five (45) days, but shall not be binding on the Governing Board.

9.3-3 TIME AND PLACE FOR HEARING

Upon receiving a request for hearing, the President of Staff shall schedule and arrange for a hearing. He or she shall give notice to the Petitioner of the time, place and date of the hearing. The date of the commencement of the hearing shall be not less than thirty (30) days from the date of receipt of the request for a hearing by the President of Staff; provided, however, that when the request is received from a Petitioner who is under a summary suspension which is then in effect, the hearing shall be held as soon as arrangements may reasonably be made, but not to exceed thirty (30) days from the date of receipt of the request for hearing by the President of Staff.

9.3-4 NOTICE OF CHARGES

As a part of, or together with the notice of hearing required by Section 9.3-3 above, the President of Staff, on behalf of the Medical Executive Committee, shall state in writing the acts or omissions with which the petitioner is charged, including a list of the charts being questioned or the grounds on which the application was denied, where applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the body whose decision prompted the hearing. The Petitioner shall furnish the CEO within fifteen (15) days a list of witnesses expected to testify at the hearing on behalf of the Petitioner.

9.3-5 HEARING PANEL/HEARING OFFICER

When a hearing is requested, the Chief Executive Officer shall appoint a Hearing Panel of three (3) members of the Medical Staff, one of whom shall be designated chair. No member of the Hearing Panel may have actively participated in the formal consideration of the matter in issue at any previous level, and no member of the Hearing Panel may be in direct economic competition with the Petitioner. Any or all of the members of the Hearing Panel may be from outside of the Medical Staff.

In the alternative to a Hearing Panel, the Chief Executive Officer may choose that the hearing be held before a single Hearing Officer.

9.3-6 FAILURE TO APPEAR

Failure, without good cause, of the Petitioner to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions

involved, and it shall thereupon become the final recommendation of the Medical Staff. Such final recommendation shall be considered by the Governing Board within forty-five (45) days but shall not be binding on the Governing Board.

9.3-7 POSTPONEMENTS AND EXTENSIONS

Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by any affected person and shall be permitted by the Hearing Panel, Chairman acting upon its behalf, or the Hearing Officer, as applicable, on a showing of good cause.

9.4 HEARING PROCEDURE

9.4-1 PRE-HEARING PROCEDURE

Each party shall promptly furnish to the other a written list of the names and addresses of the individuals, so far as then reasonably known or anticipated, who may give testimony in support of that party at the hearing. If witnesses are added after the list has been given to the other party, it shall be the duty of that party to notify the other of the change.

The failure to timely provide without good cause the names of a witness or witnesses shall prevent such witness or witnesses from appearing or testifying at the hearing. Except as hereinafter provided, no right exists to discovery of documents or other evidence in advance of a hearing, but the Presiding Officer may confer with both parties to encourage and advance mutual exchange of documents relevant to the issues to be presented at the hearing.

It shall be the duty of the Petitioner and the Medical Executive Committee, or its designee, to exercise reasonable diligence in notifying the Hearing Officer or the Hearing Panel of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, so that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be made at the hearing.

The Medical Executive Committee shall forward to the Petitioner a copy of, and/or shall provide access to all evidence on which the charges or reasons are based or will be supported at the hearing.

9.4-2 REPRESENTATION

Any party, including the Petitioner, the Medical Executive Committee and the Governing Board may be represented at the hearing or the appellate review by an attorney at law, provided the party desiring to be so represented shall give written notice to the other party(ies) and the Hearing Officer, Hearing Panel or Governing Board, as appropriate, at least fifteen (15) days prior to the commencement of the hearing. If the Petitioner does not exercise the right to be represented by an attorney at law, the Petitioner shall be entitled to be accompanied by and represented by any other person of the Petitioner's choice. The body whose decision prompted the hearing shall appoint a representative

from its membership, who shall present its recommendation, decision, or action taken and the materials in support thereof and may examine witnesses. The foregoing shall not be deemed to restrict the right of any party to the assistance or participation of legal counsel in the hearing or appellate review process.

9.4-3 THE PRESIDING OFFICER

In all hearings, a Presiding Officer shall be appointed to manage procedural matters. In the case of the appointment of a Hearing Panel, the Chairman of the Hearing Panel may serve as the Presiding Officer, or may, in his or her discretion appoint a Presiding Officer. In the case of the appointment of a single Hearing Officer, the Chief Executive Officer shall appoint a Presiding Officer. The Presiding Officer may be an attorney-at-law or another person with knowledge of general rules of hearing procedures. If the Presiding Officer is not a member of the Hearing Panel, the Presiding Officer shall not be a participant in the hearing in any other capacity. The Presiding Officer shall act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained. He or she shall be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing. He or she shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on questions which, with reasonable diligence, could not have been raised prior to the hearing and which pertain to matters of law, procedure, or the admissibility of evidence. He or she may not act as a prosecuting officer, as an advocate for the Hospital, Governing Board, Medical Executive Committee, the body whose action prompted the hearing, or the Petitioner.

9.4-4 RECORD OF THE HEARING

The Hearing Panel or Hearing Officer shall maintain a record of the hearing by a certified shorthand reporter present to make a record of the hearing, or a recording of the proceedings, the method to be determined by the Hearing Panel or Hearing Officer. The cost of any certified shorthand reporter or transcription of the court reporter's record or of any recording shall be borne equally by both parties. The Hearing Panel or Hearing Officer may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person designated by such body and entitled to notarize documents in this state or by affirmation under penalty of perjury.

9.4-5 RIGHTS OF THE PARTIES

At a hearing, both sides shall have the following rights: to ask Hearing Panel members or the Hearing Officer questions which are directly related to determining whether they are impermissibly biased and to challenge such members, to call and examine witnesses, to introduce exhibits or other documents, to cross-examine or otherwise attempt to impeach any witness who shall have testified orally on any matter relevant to the issues, otherwise to rebut any evidence, and to submit a written statement at the close of the hearing. The Petitioner may be called by the body whose decision prompted the hearing and examined as if under cross-examination. Any challenge directed at one or more members of the

Hearing Panel shall be resolved by the Hearing Panel prior to the continuation of the proceedings.

9.4-6 MISCELLANEOUS RULES

The rules of law relating to the examination of witnesses and presentation of evidence shall not apply in any hearing conducted hereunder. Any relevant evidence, including hearsay, shall be admitted by the Presiding Officer if it is the sort of evidence which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a written statement in support of his or her position and the Hearing Panel or Hearing Officer may request such a statement to be filed following the conclusion of the presentation of oral testimony. The Hearing Panel or the Hearing Officer may interrogate the witnesses or call additional witnesses if it/he/she deems such action appropriate.

9.4-7 BASIS OF DECISION

If the Hearing Panel or Hearing Officer should find the charge(s), or any of them, to be true, it shall impose such form of discipline as it shall find warranted, including such form of discipline or action that may be more stringent than that recommended by the body whose decision prompted the hearing. The decision of the Hearing Panel or Hearing Officer shall be based on the evidence produced at the hearing. Such evidence may consist of the following:

(a) oral testimony of witnesses.

(b) briefs or written statements presented in connection with the hearing.

(c) any material contained in the Hospital or Medical Staff personnel files regarding the petitioner, which shall have been made a part of the hearing record.

(d) any and all applications, references, medical records, exhibits and other documents and records which shall have been made a part of the hearing record.

(e) any other evidence admissible hereunder.

9.4-8 BURDEN OF GOING FORWARD AND BURDEN OF PROOF

The Petitioner requesting the hearing has the burden of proving by clear and convincing evidence that the action or proposed action lacks any factual basis or that the basis for the conclusion is arbitrary, capricious, unreasonable or violates the provisions of these Bylaws.

9.4-9 ADJOURNMENT AND CONCLUSION

The Presiding Officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed. The

Hearing Panel or Hearing Officer shall thereupon, outside of the presence of any other person, conduct its/his/her deliberations and render a decision and accompanying report.

9.4-10 DECISION OF THE HEARING PANEL/HEARING OFFICER

Within fifteen (15) days after final adjournment of the hearing (provided that in the event the Petitioner is currently under suspension, this time shall be as soon as possible, but not longer than ten (10) days), the Hearing Panel or Hearing Officer shall render a decision which shall be accompanied by a written report that contains findings of fact, which shall be in sufficient detail to enable the parties, any appellate review board, and the Governing Board to determine the basis for the decision on each matter contained in the notice of charges. The decision and report shall be delivered to the Medical Executive Committee, the CEO, and the Governing Board. At the same time, a copy of the report and decision shall be delivered to the Petitioner either in person or by registered or certified mail, return receipt requested. The decision of the Hearing Panel or Hearing Officer shall be considered final, subject only to the right of appeal to the Governing Board as provided in Section 9.5.

9.5 APPEALS TO THE GOVERNING BOARD

9.5-1 TIME FOR APPEAL

Within thirty (30) days after the date of receipt of the decision of the Hearing Panel or Hearing Officer, either the Petitioner or the Medical Executive Committee may request an appellate review by the Governing Board. Said request shall be delivered to the CEO in writing either in person or by certified or registered mail, return receipt requested, and it shall include a brief statement of the reasons for the appeal. If such appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon become the final action of the Medical Staff. Such final recommendation shall be considered by the Governing Board within forty-five (45) days, but shall not be binding on the Governing Board.

9.5-2 GROUNDS FOR APPEAL

The written request for an appeal shall include the grounds for appeal, and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be:

(a) substantial non-compliance with the procedures required by these Bylaws or applicable law in the conduct of the hearing and the rendering of the decision so as to deny a fair hearing;

(b) the decision was not supported by substantial evidence based on the hearing record or such additional information as may be permitted pursuant to Section 9.5-5; or

(c) the action was taken arbitrarily, unreasonably, or capriciously.

9.5-3 TIME, PLACE AND NOTICE

When appellate review is requested pursuant to the preceding subsection, the Governing Board shall, within thirty (30) days after the date of receipt of such an appeal notice, schedule and arrange for an appellate review. The Governing Board shall give the Petitioner notice of the time, place and date of the appellate review. The date of appellate review shall not be less than fifteen (15) nor more than sixty (60) days from the date of receipt of the request for appellate review, provided, however, that when a request for appellate review is from a petitioner who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed thirty (30) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Governing Board or Appeal Board, if any, for good cause shown.

9.5-4 APPEAL BOARD

When an appellate review is requested, the Governing Board may sit as the appeal board or it may appoint an appeal board which shall be composed of Governing Board members and shall have at least three (3) members. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. For the purposes of this Section, participating in an initial decision to recommend adverse action shall not be deemed to constitute participation in a prior hearing on the same matter. Upon request by the affected Petitioner, the meeting of the Governing Board may be closed in order to avoid needless and irreparable injury to the Petitioner's reputation.

9.5-5 APPELLATE REVIEW PROCEDURE

The proceedings by the appeal board shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Panel or Hearing Officer, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence is relevant and could not have been made available to the Hearing Panel or Hearing Officer in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing before the Hearing Panel or Hearing Officer; or the appeal board may remand the matter to the Hearing Panel or Hearing Officer for the taking of further relevant evidence and for decision. Each party shall have the right to present a written statement in support of his or her position on appeal, provided such statement is limited to information relevant to the issues before the Hearing Panel or Hearing Officer, and, in its sole discretion, the appeal board may allow each party or representative to personally appear and make oral argument. At the conclusion of oral argument, if allowed, the appeal board may thereupon conduct, at a time convenient to itself, deliberations in private outside the presence of the appellant and respondent and their representatives. If an appeal board is appointed, the appeal board shall present to the Governing Board its written recommendations as to whether the Governing Board should affirm, modify, or reverse the decision of the Hearing Panel or Hearing Officer, or remand the matter to the Hearing Panel or Hearing Officer for further review and decision. If no appeal board is appointed,

the procedures outlined in this subsection shall apply to a hearing before the Governing Board.

9.5-6 DECISION

Within fifteen (15) days after the conclusion of the appellate review proceedings, the Governing Board shall render a final decision in writing. The Governing Board may affirm, modify or reverse the Hearing Panel or Hearing Officer decision, or, in its discretion, remand the matter for further review and recommendation by the Hearing Panel or Hearing Officer or any other body or person. Copies of the decision shall be delivered to the petitioner and to the Medical Executive Committee, by personal delivery or by certified or registered mail, return receipt requested. If the decision is in accordance with the Medical Executive Committee's last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to further hearing or appellate review. If the decision is contrary to the Medical Executive Committee's last such recommendation, the Governing Board shall refer the matter to a joint advisory council made up of equal members of the Medical Staff and Governing Board, appointed by the President of Staff and the Chairman of the Governing Board, for further review and recommendation, and shall include in such notice of its decision a statement that a final decision will not be made until the recommendations of the joint advisory council have been considered.

9.5-7 FURTHER REVIEW

Except where the matter is remanded for further review and recommendation pursuant to Section 9.5-6, the final decision of the Governing Board following the appeal procedures set forth in this Article shall be effective immediately and shall not be subject to further review. However, if it is remanded to the Hearing Panel or Hearing Officer or any other body or person, said committee, body, or person shall promptly conduct its review and make its recommendations to the Governing Board in accordance with the instructions given by the Governing Board. This further review process and the time required to report back shall in no event exceed thirty (30) days in duration, except as the parties may otherwise stipulate.

9.5-8 RIGHT TO ONE HEARING

Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled as a right to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of action by either the Medical Executive Committee or the Governing Board or by both.

9.5-9 MANDATORY REPORTING

Final disciplinary action approved by the Hospital Governing Board, that results in a limitation, suspension, or revocation of a Practitioner's Clinical Privileges, or any voluntary surrender or limitation of privileges, for reasons relating to professional competence or professional conduct shall be reported to all appropriate authorities by the CEO, in accordance with the requirements of federal and state laws.

9.6 EXCEPTIONS TO HEARING RIGHTS

9.6-1 CLOSED STAFF OR EXCLUSIVE USE DEPARTMENTS

The fair hearing rights of Articles VIII and IX do not apply to a Practitioner whose application for Medical Staff membership and privileges was denied on the basis that the privileges he or she seeks are granted only pursuant to a closed staff or exclusive use policy. Such Practitioners shall have the right, however, to request that the Governing Board review the denial, and the Governing Board shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the Practitioner may personally appear before and/or submit a statement in support of his or her position to the Governing Board.

9.6-2 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

No hearing is required, except as otherwise stated, when a member's license or legal credentials to practice have been revoked or suspended as set forth in Section 8.3.

ARTICLE X:
OFFICERS

10.1 OFFICERS OF THE MEDICAL STAFF

10.1-1 IDENTIFICATION

The officers of the Medical Staff shall be:

(a) President of the Medical Staff;

(b) Vice President; and

(c) Secretary-Treasurer.

10.1-2 QUALIFICATIONS

Each general officer must:

(a) be a member of the Active staff in good standing for two (2) years and actively involved in patient care at the Hospital at the time of nomination and election and remain a member in good standing during his or her term of office.

(b) have demonstrated executive and administrative ability through experience and prior constructive participation in staff activities and be recognized for a high level of clinical competence.

(c) have demonstrated a high degree of interest in and support of the medical staff and hospital by his or her staff tenure and his or her level of clinical activity at this hospital.

(d) agree and if elected, in practice willingly and faithfully discharge the duties and exercise the authority of the office held and work with the other general and departmental officers of the staff and with the Chief Executive Officer, the Governing Board and its committees.

(e) have a record free of adverse recommendations concerning medial staff appointments, privileges, license, Drug Enforcement Agency sanctions, and professional conduct or quality issues within the last 5 years. After 2 years in good standing nominees may request Governing Board and Medical Executive Committee approval to serve as an officer.

(f) have received medical staff leadership training or demonstrate a willingness to attend such training once every year.

(g) demonstrate the ability to work positively and communicate well with colleagues, hospital administration and the Governing Board.

(h) not simultaneously hold a leadership position on another hospital's medical staff or in a facility that directly competes with Waverly Health Center. Noncompliance with this requirement will result in the officer being automatically removed from office.

A Practitioner may not hold simultaneously two or more general staff offices.

10.1-3 NOMINATIONS

The Medical Executive Committee convenes at least 28 days prior to an annual meeting at which an election for officers is to occur for the purpose of nominating one or more qualified candidates for each of the offices of President, Vice President, and Secretary-Treasurer of the Medical Executive Committee. This list is promptly published to all Active staff members in good standing. Additional nominations may be submitted by written petition signed by at least ten (10) percent of said Active members, filed with the chair of the Executive Committee at least ten (10) days in advance of the annual staff meeting and accompanied by evidence of the candidate's qualifications and of his or her willingness to be nominated. The Executive Committee finalizes the slate, including the names of those nominated by written petition.

If before the election, all of the individuals nominated and approved, either refuse, are disqualified from, or otherwise are unable to accept nomination, then the Medical Executive Committee submits substitute nominees at the annual meeting, and nominations from the floor offered and seconded by active staff members in good standing will be accepted. All such nominations must be presented with evidence of the candidate's qualifications and of his or her willingness to be nominated. Election of any officer nominated is subject to board approval.

10.1-4 ELECTION

The President, Vice President, and Secretary-Treasurer are chosen, subject to Governing Board approval and from among the candidates nominated, by election by majority vote cast by those Active staff members in good standing who are present at the Medical Staff's annual meeting. Voting shall be by a voice vote. If no candidates for a given office receive a majority vote on the first poll, a run-off election is held immediately between the two candidates receiving the highest number of votes.

10.1-5 TERM OF OFFICE; VACANCY; SUCCEEDING OFFICERS; ASSISTANTS

All officers shall serve a two (2) year term commencing on the first day of the Medical Staff Year following their election, except that an officer elected or appointed to fill a vacancy assumes office immediately upon election or appointment. Each officer shall serve until the end of his or her term and until a successor is elected, unless he or she shall sooner resign or be removed from office. Officers shall not be permitted to succeed themselves.

In the event of a vacancy in the office of President, the Vice President shall assume the office of President and complete the unexpired term. In the event of a vacancy in the office of the Vice President, the Secretary-Treasurer shall assume the office of Vice President and complete the unexpired term. In the event of a vacancy in the office of Secretary-Treasurer, an election by the Medical Staff will be held to name a replacement to complete the unexpired term.

The Medical Executive Committee may authorize the use of assistants or staff persons to aid the officers and committees.

10.1-6 REMOVAL OF ELECTED OFFICERS

A request for the removal of an officer must be submitted to the Hospital Chief Executive Officer by a voting member of the Medical Staff. The Practitioner initiating the request will be required to provide written reason why the particular practitioner is no longer fit for the special office he or she is holding. The Chief Executive Officer will review the charges, discuss them with the Medical Executive Committee, and then if the information is substantiated, arrange to have the matter brought to the Medical Staff for a vote at the next regular meeting. Any officer of the Medical Staff may be removed from office by a two-thirds (2/3) vote by secret ballot of the Medical Staff at any regular or special meeting of the Medical Staff, provided the member involved has been informed at least forty-eight (48) hours before the meeting and is given at least fifteen (15) minutes at the meeting to make a presentation. The ballots shall be counted by the Secretary-Treasurer of the Medical Staff (except when he or she is the subject of the balloting, in which case the President of the Medical Staff shall count the ballots) and the CEO. Removal shall be effective upon the approval of the Hospital Governing Board. Inasmuch as no practice privileges are involved, no appeal will be allowed when it pertains only to the removal from office, and the Practitioner shall not be entitled to hearing rights under Article IX.

If an officer ceases to be a member in good standing of the Active Medical Staff, or loses a contract or employment relationship with the Hospital or suffers a loss or significant limitation of practice privileges, that member shall be removed from office by the Medical Executive Committee.

10.1-7 GROUNDS FOR REMOVAL

Grounds for removal of any officer of the Medical Staff, shall include, but not be limited to:

(a) failure to perform the duties of the position held in a timely and appropriate manner.

(b) failure to continuously satisfy the qualifications for the position.

(c) having an automatic or summary suspension imposed by operation of Section 8.2 or 8.3 of these Bylaws or a corrective action matter pursuant to Section 8.1 of these Bylaws resulting in a final decision other than to take no action.

(d) conduct or statements inimical or damaging to the best interests of the medical staff or the hospital or to its goals, programs, or public image.

(e) physical or mental infirmity that renders the officer incapable of fulfilling the duties of his or her office.

(f) verifiable professional incompetence.

(g) improper professional conduct.

(h) disruptive behavior such as described in the Disruptive or Impaired Practitioner policies of the Medical Staff or Hospital.

10.2 DUTIES OF OFFICERS

10.2-1 PRESIDENT

The President shall serve as the chief administrative officer of the Medical Staff and is the person principally responsible for the medical direction of the Hospital. The duties of the President shall be to:

(a) act in coordination and cooperation with the CEO in all matters of mutual concern within the Hospital including quality of patient care within the Hospital;

(b) call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

(c) serve as Chairman of the Medical Executive Committee;

(d) serve as an ex officio member of all other Medical Staff committees without vote, unless his or her membership in a particular committee is required by these Bylaws;

(e) be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner;

(f) except as otherwise provided, appoint committee members to all standing, special and multi-disciplinary Medical Staff committees, except the Medical Executive Committee;

(g) be the spokesman for the Medical Staff in its external professional and public relations;

(h) shall serve as a liaison representative between the Medical Staff and Governing Board representing the views, policies, needs and grievances of the Medical Staff

to the Governing Board and to the CEO, and interpreting the policies of the Governing Board to the Medical Staff;

(i) perform such other functions as may be assigned to him or her by these Bylaws, by the membership, by the Medical Executive Committee, or by the Governing Board;

(j) be empowered to act as consultant and arbiter in all Staff and Service affairs;

(k) actively promote improvement in patient care, hospital teaching, and service organization;

(l) be responsible to the Medical Staff and the Governing Board for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with the procedural safeguards in all instances where corrective action has been requested against a practitioner;

(m) serve as the responsible representative of the Medical Staff to receive, and interpret the policies of the Governing Board to the Medical Staff and to report and interpret to the Governing Board, in return, on the performance and maintenance of quality medical care as authorized under the laws of the State of Iowa;

(n) serve as a member of, or assign a Medical Staff member to the Hospital Ethics Committee; and

(o) appoint Medical Directors for each Hospital patient care department.

10.2-2 VICE PRESIDENT OF STAFF

In the absence of the President of Staff, the Vice President of Staff shall assume all duties and the authority of the President of Staff. The Vice President of Staff shall be a voting member of the Medical Executive Committee, shall perform such other supervisory duties as the President may assign and shall carry out such other functions as may be delegated to him or her by these Bylaws by the membership, by the Medical Executive Committee or by the Governing Board.

10.2-3 SECRETARY-TREASURER

The Secretary-Treasurer shall be a member of the Medical Executive Committee, maintain a roster of members, keep accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings, call meetings on order of the President, be responsible for notification and collection of Medical Staff dues and shall notify members of all meetings, and keep a record of all members' attendance; keep, or cause to be kept, an accurate record of all increments and disbursements of the Staff funds, and shall be responsible for their safekeeping and shall submit the Treasurer's annual report to the Staff; serve as a voting member of the Executive Committee; and attend to all

correspondence, receive, safeguard and be accountable for all funds of the Medical Staff and perform such other duties as ordinarily pertain to his or her office or as may be assigned to him or her.

ARTICLE XI:
CLINICAL DEPARTMENTS

11.1 ORGANIZATION OF DEPARTMENTS

There shall be Departments as designated by the Medical Staff. Each Department may be headed by a Department Chair or may function under guidance of the Medical Executive Committee.

11.2 DEPARTMENT CHAIRS

11.2-1 QUALIFICATIONS

Each Chair shall be a member of the Department which he or she is to head, shall be qualified by training, experience, interest and demonstrated current ability in the clinical area covered by the Department, and shall be willing and able to discharge the administrative responsibilities of his or her office.

11.2-2 SELECTION

For purposes of these Bylaws, a Chair of a Department serving on a voluntary basis is referred to as a "Voluntary Chair," and one serving as such by contract or on some other full or part time basis with the hospital is referred to as a "Contract Chair".

A Voluntary Chair is elected by a majority vote by secret ballot of those members of the Department in good standing who are eligible and qualified to vote for Department officers and who are present at the regular final Department meeting in any year in which the Department chairperson is to be elected, and subject to the approval of the Governing Board. Nominations may be made and seconded at the meeting by any Active Staff Member of the Department in good standing, provided that evidence is presented to the meeting of the qualifications of the nominee and that the nominee accepts the nomination.

11.2-3 TERM OF OFFICE

In the event that there is more than one qualified member of a Department to serve as Chair, each Chair shall serve a two-year term, commencing on his or her appointment. He or she shall serve until the end of the succeeding Medical Staff Year and until his or her successor is chosen, unless he or she shall sooner resign or be removed from office. A Chair may be removed by a majority vote of the Governing Board or of the Medical Executive Committee with the approval of the Governing Board.

11.2-4 DUTIES

Each Chair shall:

(a) be accountable to the Medical Executive Committee for all the effective operation of his or her Department;

(b) develop and implement programs to carry out the quality review, evaluation and monitoring functions assigned to his or her Department, and report regularly thereon to the Medical Executive Committee;

(c) exercise general supervision over all clinical work performed within his or her Department;

(d) be responsible for implementation within his or her Department of actions taken by the Medical Executive Committee or the Medical Staff;

(e) conduct investigations and submit reports and recommendations to the Medical Executive Committee, as requested, concerning the appointment or reappointment and the clinical privileges to be exercised by Practitioners applying for or practicing in his or her Department;

(f) assist in the teaching, education and research program in his or her Department;

(g) act as Presiding Officer at all Department meetings;

(h) assist in the preparation of such annual reports, including budgetary planning, pertaining to his or her Department as may be required by the Medical Executive Committee, the CEO, or the Governing Board; and

(i) perform such other duties commensurate with his or her office as may from time to time be reasonably requested of him or her by the President of Staff, the Medical Executive Committee, or the Governing Board.

11.3 FUNCTIONS OF DEPARTMENT

(a) Assure that patient care reviews are conducted for the purpose of analyzing and evaluating the quality of care and appropriateness of treatment provided to patients within the Department. The number of such reviews to be conducted during the year shall be conducted in accordance with such procedures as may be adopted by the Hospital or Medical Executive Committee. Each Department shall also identify actions that should be taken in order to resolve identified problems in patient care and clinical performance and evaluate the effectiveness of action which has been taken in such problems. The Medical Executive Committee may assign certain case review responsibilities, such as surgical cases and tissue review, to other committees.

(b) Submit reports to the Medical Executive Committee and Medical Staff concerning: (1) findings of the Department's review, evaluation and monitoring activities, acts taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the Department in the Hospital. If such reports are oral, a written summary of the oral report shall be prepared.

(c) Assist in establishing guidelines for the granting of clinical privileges within the Department and submit the recommendations, as requested, regarding the Clinical Privileges each member or applicant should be authorized to exercise.

(d) Conduct or participate in, and make recommendations regarding the need for, continuing education programs pertinent to changes in the state-of-the-art and regarding findings of review, evaluation and monitoring activities.

(e) Monitor, on a continuing and concurrent basis, adherence to: (1) Medical Staff and Hospital policies and procedures; (2) requirements for alternate coverage and for consultations; (3) sound principles of clinical practice; and (4) fire and other regulations designed to promote patient safety.

(f) Coordinate the patient care provided by the Department's members with nursing and with administration.

(g) Establish such committees and other mechanisms as are necessary and desirable to properly perform the functions assigned to it.

11.4 ASSIGNMENT TO DEPARTMENTS

Each Practitioner shall be assigned membership in at least one Department, but may be granted membership and/or Clinical Privileges in one or more of the other Departments. The exercise of privileges within each Department shall be subject to the Rules and Regulations thereof and to the authority of the Department.

11.5 REMOVAL OF DEPARTMENT CHAIR

Removal of a Department Chair may be affected by the President, subject to the approval of the Medical Executive Committee and the Governing Board.

ARTICLE XII:
COMMITTEES & GENERAL DUTIES

12.1 GENERAL

12.1-1 DESIGNATION

The Committees described in this Article shall be the Standing Committees of the Medical Staff. Unless otherwise specified, the members of such Committees and the Chairman of such Committees shall be appointed by the President of Staff, subject to the approval of the Medical Staff, and such Committees shall be responsible to the Medical Staff. Unless membership on a Committee is otherwise specified in these Bylaws, the President of Staff may appoint representatives of Hospital Management, Nursing Service, Medical Records, Pharmacy and other Hospital departments or services as may be necessary or desirable. The CEO may attend any meetings of any medical staff committees at the discretion of the committee chair, the Governing Board, or the CEO, unless his or her membership on a committee is expressly required in these Bylaws. Unless otherwise specified, the CEO's participation shall be ex officio without vote.

In addition, Special Committees may be created by the President with the approval of the Medical Staff on an ad hoc basis to perform specified tasks. Such Committees shall terminate at the end of the Medical Staff Year unless they are renewed by the Medical Executive Committee. The members of special Committees shall also be appointed by the President, subject to the approval of the Medical Staff.

Whenever these Bylaws require that a function be performed by, or that a report or recommendation be submitted to:

(a) a named Committee, but no such Committee exists, the Medical Executive Committee shall perform such function or receive such report or recommendation or shall assign the functions of such Committee to a new or existing Committee of the Medical Staff or to the Staff as a whole.

(b) the Medical Executive Committee, but a standing or special Committee has been formed to perform the function, the Committee so formed shall act in accordance with the authority delegated to it.

The functions of any committee may be carried out by the Medical Staff as a whole, unless otherwise specified in these Bylaws.

12.1-2 TERMS AND REMOVAL OF COMMITTEE MEMBERS

Unless otherwise specified, a Committee member shall be appointed for a term of one year, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the Committee. Any Committee member who is appointed by the President may be removed by a majority vote of the Medical Staff. The removal of any Committee member who is automatically

assigned to a Committee because he or she is a general officer or medical administrative officer shall be governed by the provisions pertaining to removal of such officers.

12.1-3 VACANCIES

Unless otherwise specified, vacancies on any Committee shall be filled in the same manner in which an original appointment to such Committee is made.

12.1-4 CONDUCT AND RECORDS OF MEETINGS

Committee meetings shall be conducted and documented in the manner specified for such meetings in Article XIII.

12.1-5 VOTING

Unless otherwise specified, only members of the Medical Staff shall be entitled to vote on Medical Staff Committees.

12.1-6 PRIVILEGE AND CONFIDENTIALITY

Any and all activities undertaken by any Committee for the purpose of achieving and maintaining quality patient care, evaluating the competency of a Practitioner, or reducing morbidity and mortality, and all data, documents, reports, and records related thereto, shall be privileged and confidential pursuant to federal and state laws.

12.1-7 PARTICIPATION ON INTERDISCIPLINARY HOSPITAL COMMITTEES

Staff functions and responsibilities relating to liaison with the Governing Board and the Hospital administration, related to Hospital accreditation, disaster planning, facility and services planning and financial management shall be discharged by the appointment of Medical Staff appointees to such Hospital functions by the President of the Medical Staff.

12.2 MEDICAL EXECUTIVE COMMITTEE

12.2-1 COMPOSITION

The Medical Executive Committee shall consist of the officers of the Medical Staff, namely President of Staff, Vice President of Staff, and Secretary-Treasurer. The Chief Executive Officer and the Chief Executive Officer's designee shall also serve on the Medical Executive Committee and attend meetings, as ex-officio committee members.

12.2-2 DUTIES

The duties of the Medical Executive Committee shall be to:

(a) represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

(b) coordinate the activities and general policies of the Medical Staff not otherwise established as the responsibility of the Departments;

(c) receive and act upon Department and Committee reports and recommendations;

(d) implement policies of the Medical Staff not otherwise the responsibility of the Departments;

(e) recommend action to the CEO on matters of a medico-administrative nature;

(f) fulfill the Medical Staff's accountability to the Governing Board for the medical care rendered to patients in the Hospital;

(g) review the credentials of applicants and to make recommendations for Staff membership, assignments to Departments, and delineation of Clinical Privileges;

(h) review periodically all information available regarding the performance and clinical competence of Staff members, and other Practitioners, and, as a result of such reviews, make recommendations for reappointments and renewals or changes in clinical or practice privileges;

(i) take all reasonable steps to ensure professionally ethical conduct on the part of all Practitioners, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;

(j) report at each general Staff meeting;

(k) perform such other functions as may be assigned to it by these Bylaws, by the Medical Staff or by the Governing Board;

(l) conduct an annual review of the Bylaws, Rules and Regulations of the Medical Staff; receive comments and recommendations regarding these matters from the Medical Staff, the President, the Departments, the Governing Board and the CEO; and submit recommendations to the Medical Staff and the Governing Board for changes in these documents;

(m) when at least two of the three officers are present, is empowered to act for the Medical Staff on a daily basis;

(n) to keep the Medical Staff informed of the requirements of the applicable accreditation entity and the Hospital's status as an accredited organization;

(o) review and evaluate reports which are referred to it by the Chief Executive Officer, the President of Staff, or the Professional Performance Council or other committees; and

(p) to review and evaluate the certification and credentials of paramedical or affiliate personnel that function in the hospital as employees of Medical Staff members and report to the Medical Staff accordingly.

12.2-3 MEETINGS

The Medical Executive Committee shall meet once a month or as needed, and shall maintain a permanent record of its proceedings and actions. A physician shall serve as Chair. The Medical Staff Executive Committee shall be empowered to function as a committee of the whole Medical Staff, if needed, and if meeting as a committee of the whole Medical Staff, the minutes will reflect Executive Committee activities as separate from the Medical Staff's general minutes.

12.3 PROFESSIONAL PERFORMANCE COMMITTEE (PPC)

12.3-1 COMPOSITION

The composition of the PPC will be a minimum of 3 Physicians who all must be in the Active Category of the Medical Staff, and shall also include the Chief Nursing Officer, the Director of Quality Services, the Medical Staff Coordinator, and may include a Midlevel. The Medical Staff members shall have a rotating membership, each serving approximately 2-3 years, as needed. The chairperson shall be a physician elected by majority vote of the members of the PPC.

12.3-2 DUTIES

The duties of the Professional Performance Committee shall be to:

(a) conduct professional review activities and projects through case review and recommendation, monitoring of clinical measures, and monitoring of general competencies to ensure continual improvement of the Hospital's clinical services.

(b) communicate case review results to members of the Medical Staff through a practitioner profile; and

(c) forward case review results and recommendations to the Medical Executive Committee.

12.3-3 MEETINGS

The Professional Performance Committee shall meet on a regular basis as needed, and shall maintain a permanent record of its proceedings and actions.

12.4 PHARMACY AND THERAPEUTICS COMMITTEE

12.4-1 COMPOSITION

The Pharmacy and Therapeutic Committee shall consist of a Medical Staff member appointed by the President of the Medical Staff, the Hospital pharmacist, and the Chief Nursing Officer. The Committee shall also include the following, but is not limited to a representative from Employee and Patient Safety, Nutrition Services, and Quality Services. Basic Duties

(a) Be responsible for the development and surveillance of all drug utilization policies and practices within the hospital in order to facilitate optimum clinical results and a minimum potential for hazard.

(b) Assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the hospital.

(c) Serve as an advisory group to the hospital Medical Staff and the Pharmacist on matters pertaining to the choice of available drugs.

(d) Monitor and evaluate frequently prescribed drug(s), drug(s) having potential for significant risk to patient, drug(s) suspected to be problem prone, and drug(s) as critical component of the care provided for a specific diagnosis, condition or procedure.

(e) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.

(f) Develop and review periodically a formulary or drug list for use in the hospital.

(g) Prevent unnecessary duplication in stocking and drugs in combination having identical amounts of the same therapeutic ingredients.

(h) Evaluate clinical data concerning new drugs or preparations requested for use in the hospital.

(i) Review all untoward drug reactions.

(j) Make recommendations to the Medical Staff.

(k) Seek to resolve problems which may arise involving the Pharmacy, nursing and practitioners.

12.4-2 MEETINGS

The Pharmacy and Therapeutic Committee shall meet twice a year.

12.5 EMERGENCY DEPARTMENT COMMITTEE

12.5-1 COMPOSITION

The Committee will consist of the Emergency Department Directors and at least one other representative of the Medical Staff.

12.5-2 BASIC DUTIES

(a) Maintain high standards of medical care in the Emergency Department.

(b) Develop and implement Emergency Department policies.

(c) Assist in the education of the Emergency Department medical and nursing staff.

(d) Coordinate the physician coverage and the on-call specialty coverage.

(e) Review quality of medical care and administrative problems on a regular basis.

(f) Report from time-to-time and at least annually to the Medical Executive Committee.

(g) Approve and maintain a procedure manual for the Emergency Department.

(h) Develop policies and procedures relative to emergency treatment of patients experiencing cardiac arrest.

(i) Review all cardiac arrest cases.

(j) Report to the Medical Executive Committee on activities of all meetings.

12.5-3 MEETINGS

The Committee shall meet at least quarterly and a physician will act as Chair.

12.6 INFECTION PREVENTION COMMITTEE

12.6-1 COMPOSITION

A member of the Medical Staff shall chair the Infection Prevention Committee having representative members from Administration, Nursing and other departments as required.

12.6-2 BASIC DUTIES

(a) Establish a system of infection reporting which will include those infections brought into the hospital, those acquired within the hospital and becoming manifest while in the hospital or upon discharge from the hospital.

(b) Review reports of these actual infections.

(c) Promotion and enforcement of hospital isolation procedures including in-service education of all personnel.

(d) Review of Operating Room, Delivery Room, Recovery Room, Radiology and special care unit procedures in regards to their special handling of infected cases.

(e) Periodically review the sterilization procedures as done by Central Supply, Pharmacy, Operating Room, Respiratory Therapy, Anesthesia and other services involved in sterilization of instruments of patient apparatus.

(f) When outbreaks of infections are suspected, conduct epidemiological surveys which include the periodic testing of hospital personnel for carrier status.

(g) Review policies and definitions related to sanitation and standards of asepsis.

(h) When there is reasonably felt to be a danger to any patient or personnel, to institute through its Chair or physician members any appropriate control measures or studies.

(i) Report at least quarterly to the Medical Executive Committee.

12.6-3 MEETINGS

(a) The Committee shall meet at least quarterly.

(b) A permanent record will be maintained of all findings, proceedings and actions taken

12.7 BOARD QUALITY COMMITTEE (BQC)

12.7-1 COMPOSITION

The composition of the Board Quality Committee will include one (1) physician who must be in the Active Category of the Medical Staff, and shall also include a member of the Governing Board, the Chief Executive Officer, a senior nursing officer, and the Director of Quality Services. The physician member will have a rotating membership, serving approximately 2-3 years, as needed.

12.7-2 BASIC DUTIES

(a) Provide guidance to the Governing Board regarding improvement efforts to meet the Hospital's mission.

(b) Review and provide advice and comment on Hospital performance indicators.

(c) Review and provide advice and comment on departmental performance indicators.

12.7-3 MEETINGS

(a) The Committee shall meet regularly, as needed.

(b) A permanent record will be maintained of all findings, proceedings and actions taken.

(c) The chairperson shall be elected by majority vote of the members of the BQC.

12.8 TISSUE CASE REVIEW

12.8-1 COMPOSITION

Tissue Case Review shall be conducted by two physicians, one of which is the Hospital's pathologist.

12.8-2 BASIC DUTIES

The duties shall include a study and report on the agreement or disagreement among the pre-operative, post-operative and pathological diagnosis, and on whether the surgical procedures undertaken in the Hospital are acceptable. The complete and detailed report shall be provided to the Medical Executive Committee on a quarterly basis.

All surgical and gynecological cases on which there has been a controversy of proper surgical management will be referred to the Professional Performance Committee for review.

12.8-3 CASE REVIEWS

Tissue case reviews shall be completed quarterly.

12.9 OTHER SPECIAL COMMITTEES & DUTIES

All other Committee functions and general duties not specified above shall be the responsibility of the Medical Executive Committee. The President of the Medical Staff shall also be authorized to appoint such other committees as shall from time to time be deemed necessary or desirable. Such Committees shall confine their work to the purpose for which they were created and shall report to the full Medical Staff unless otherwise specified. Special Committees shall not have power to act unless such power is specifically granted by the motion which created the Committee.

12.10 RELATIONSHIP OF STAFF MEMBER TO COMMITTEES

Any committee shall, if deemed necessary, make recommendations for any changes in existing procedures and practices or the adoption of any new procedures for the well being of the hospital patients, but no such recommendation shall become operative without having first been presented to the Staff for consideration and approval at any regularly convened meeting of Medical Staff. After due consideration, the Staff shall notify the Committee of its decision to

reject or approve said recommendation, or may request further information relative to said recommendation.

Members of the Medical Staff shall represent the Medical Staff as official members of various hospital committees. As members of these committees, they help establish policies that maintain quality patient care. Membership of committees is established by office, specialty, or appointment by the President of the Medical Staff. These committees include Hospital Planning Committee, Infection Prevention Committee, Hospital Finance Committee and Emergency Committee.

ARTICLE XIII:
MEETINGS

13.1 MEETINGS

13.1-1 ANNUAL MEETING

The annual meeting of the Medical Staff shall be held in December. At this meeting the retiring officers and committees shall make such reports as may be required, officers for the ensuing year shall be elected, and the President shall present a report on actions taken during the year and on other matters believed to be of interest to the membership. If the annual meeting is held on a date other than in December, notice of the annual meeting shall be given to the membership at least twenty (20) days prior to the meeting.

13.1-2 REGULAR MEETINGS

There shall be a regular meeting of the Medical Staff on the third Monday of each even-numbered month.

The Medical Staff shall, by standing resolution, designate the date, time and place for all regular Staff meetings. Notice of the original resolution and any changes thereto shall be given to each member of the Staff in the same manner as provided in Section 13.1-4 of this Article XIII for notice of a special meeting.

13.1-3 AGENDA

The agenda at any regular meeting shall be set by the President of the Medical Staff, but shall include at least the following elements:

(a) Educational Session - As the need arises, the agenda of a regular Medical Staff meeting shall include a session which relates to Performance Improvement..

(b) Business Agenda:

(1) Call to order.

(2) Approval of the minutes of the last regular and of all special meetings.

(3) Approval of the Executive Committee Minutes.

(4) Departmental Reports.

(5) CEO's Report.

(6) Treasurer's Report.

(7) Old Business.

(8) New Business.

(9) Adjournment.

13.1-4 SPECIAL MEETINGS

(a) Special meetings of the Medical Staff may be called at any time by the President, at the request of the Governing Board or forty percent (40%) of the Active Medical Staff in good standing. At any special meeting no business shall be transacted except that stated in the notice calling the meeting. Medical Staff members shall be notified at least forty-eight (48) hours prior to the time of the meeting. The attendance of a member of the Medical Staff at a special meeting shall constitute waiver of notice of such meeting.

(b) The agenda at special meetings shall be:

(1) Reading of the notice calling the meeting.

(2) Transaction of business for which the meeting was called.

(3) Adjournment.

13.2 QUORUM

The presence of fifty percent (50%) (but not less than two) of the total membership of the Active Medical Staff at any regular, annual or special Medical Staff meeting shall constitute a quorum.

13.3 ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be required by these Bylaws. The Chair shall be permitted to vote. No proxy voting and no cumulative voting shall be permitted. Committee action may be conducted by telephone conference which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Action may be taken without a meeting by a writing setting forth the action so taken signed by each member entitled to vote thereat.

All meetings of the Medical Staff shall be governed by Roberts Rules of Order, Revised.

Persons serving under these Bylaws as ex officio members of a committee shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum and shall not have a vote.

13.4 MINUTES

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the Secretary and forwarded to the Medical Records Office. Each Committee and Department shall maintain a

permanent file of the minutes of each meeting. Medical Staff functions, when conducted by the Medical Executive Committee will be identified in the minutes by asterisk.

13.5 ATTENDANCE REQUIREMENTS

13.5-1 GENERAL

(a) Each member of the Active Staff shall be required to attend at least two-thirds (2/3rds) of all Medical Staff meetings in each year. A member who is compelled to be absent from any Staff Meeting due to a medical leave of absence or work related absence from the community shall promptly notify the Chief Medical Officer prior to the meeting regarding the reason for such absence. Unless excused for good cause, failure to meet the annual attendance requirements, or unexcused absence from three consecutive regular meetings, shall be reviewed by MEC and the practitioner may be placed in provisional status as outlined in Section 4.6. Failure to rectify attendance during the 6 month provisional period shall immediately suspend such practitioner for a period of 30 days. Should an Active Medical Staff Member be placed in provisional status for a second time due to failure to meet attendance requirements, their privileges shall be immediately suspended for a period of 60 days. Any further non-compliance regarding attendance requirements should be considered a voluntary resignation from the Medical Staff and shall result in automatic termination.

(b) Reinstatement to the Active Medical Staff of members whose membership has been revoked because of absences from meetings may be made on application, the procedure being the same as in applications for original appointment, after having attended 4 of 6 Medical Staff meetings in the same year. Such Medical Staff Member shall also incur the cost of reinstatement of their Active Staff membership.

(c) Meeting attendance by members of the Courtesy and Consulting Staffs generally shall not be required. The President of the Medical Staff may invite others to attend meetings.

13.5-2 SPECIAL ATTENDANCE FOR CASE PRESENTATION

(a) At the discretion of the chair or presiding officer, when a member's clinical practice or conduct is scheduled for discussion at a regular Department or Committee meeting, the member may be requested to attend. If such Practitioner is not otherwise required to attend the regular monthly Staff meeting, the President of the Staff shall so inform the CEO who shall give the Practitioner advance written notice of the day, time and place of the meeting at which his or her attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the practitioner shall so state, shall be given by certified mail, return receipt requested, and shall include a statement that his or her attendance at the meeting at which the apparent or suspected deviation is to be discussed is mandatory.

(b) Failure by a Practitioner to attend any meeting with respect to which he or she was given notice that attendance was mandatory, unless excused by the President or his or her designee upon a showing of good cause, shall result in an automatic suspension of all or such portion of the Practitioner's Clinical Privileges as the Medical Executive Committee may direct, and such suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee, as provided in Section 8.3-1. If the President is the Practitioner involved, the Medical Executive Committee shall consider his or her excuse for good cause. If the Practitioner shall make a timely request for postponement supported by an adequate showing that his or her absence will be unavoidable, such presentation may be postponed by the President, or by the Medical Executive Committee if the President is the Practitioner involved, until not later than the next regular staff meeting; otherwise, the pertinent clinical information shall be presented and discussed as scheduled.

13.6 COMMITTEE AND DEPARTMENT MEETINGS

13.6-1 REGULAR MEETINGS

Committees and Departments may, by resolution, provide the time for holding regular meetings, and no notice other than such resolution shall then be required.

13.6-2 SPECIAL MEETINGS

A special meeting of any Committee or Department may be called by or at the request of the Chairman or Chief thereof, by the President of the Medical Staff, the Medical Executive Committee, or by one-third of the group's then members, but not less than two members.

13.6-3 NOTICE OF MEETINGS

Written or oral notice of the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the Committee or Department not less than seventy-two (72) hours before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited postage prepaid in the United States Mail addressed to the member at his or her address as it appears on the records of the Hospital. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

13.6-4 QUORUM

A quorum of fifty percent (50%) of the voting membership shall be required at Executive Committee meetings. For other Committees and Departments, a quorum shall consist of one/third (1/3) of the voting members but in no event less than two voting members, one of whom shall be a physician.

13.6-5 EX OFFICIO MEMBERS

Persons serving under these Bylaws as ex officio members of a Committee shall have all rights and privileges of regular members, except they shall not be counted in determining the existence of a quorum and shall not be entitled to vote.

13.6-6 ATTENDANCE

Each Committee or Department member shall be required to attend not less than fifty percent (50%) of all meetings of his or her Committees or Departments in each year. The reason provided for any absences and the action of the Committee Chairman or Department Chair thereon shall be shown in the minutes. The failure to meet the foregoing annual attendance requirements, unless excused by the Committee Chairman for good cause shown, shall be grounds for any of the corrective actions specified in Section 8.1-5, including, in addition, removal from a Committee or Department. Committee Chairmen and Department Chair shall report such failures to the Medical Executive Committee for action. Attendance at Committee and Department meetings shall apply to all persons assigned to Committees and Departments.

13.7 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be executed according to Robert's Rules of Order, Revised; however, technical failure to follow such rules shall not invalidate action taken at such a meeting.

ARTICLE XIV:
CONFIDENTIALITY, IMMUNITY AND RELEASES

14.1 SPECIAL DEFINITIONS

For the purposes of this Article, the following definitions shall apply in addition to the defined terms of these Bylaws:

(a) INFORMATION means all acts, communications, records of proceedings, minutes, other records, reports, memoranda, statements, recommendations, data and other disclosures, whether in written, recorded, computerized or oral form, relating to professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

(b) REPRESENTATIVE means a board, any director, a committee, a chief executive officer or administrator of a hospital or other health care institution or their designee, a medical staff entity, an organization of health practitioners, a professional review organization, a state or local board of medical or professional quality assurance organization, and any member, officer, department, service or committee thereof, and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

(c) THIRD PARTIES means both individuals and organizations providing information to any representative.

14.2 AUTHORIZATIONS AND CONDITIONS

By applying for or exercising clinical or practice privileges within this Hospital, a Practitioner thereby:

(a) authorizes Representatives of the Hospital and the Medical Staff to solicit, provide and act upon information bearing, or reasonably believed to bear, on his or her professional ability and qualifications.

(b) authorizes Third Parties and their Representatives to provide information, including otherwise privileged or confidential information, concerning such Practitioner to the Hospital and its Medical Staff.

(c) agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative who acts in accordance with the provisions of this Article.

(d) acknowledges that the provisions of this Article are express conditions to his or her application for or acceptance of Medical Staff membership and the continuation of such membership or to his or her exercise of Clinical Privileges at this Hospital, or to his or her application for or acceptance of approval and exercise of practice privileges at this Hospital.

14.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any Practitioner submitted, collected or prepared by any Representative for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality or contributing to clinical research shall be confidential, to the fullest extent permitted by law, and shall not be disseminated to anyone other than a Representative, nor be used in any way except as provided herein or except as otherwise required by law. Such privilege confidentiality shall also extend to Information of like kind that may be provided by Third Parties. This Information shall become a part of the Hospital peer review files and shall not become part of a particular patient's file.

14.4 IMMUNITY FROM LIABILITY

14.4-1 FOR ACTION TAKEN

Each Representative of this Hospital, including its Medical Staff members, shall be exempt, to the fullest extent permitted by law, from liability to a Practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his or her duties as a Representative.

14.4-2 FOR PROVIDING INFORMATION

Each Representative of this Hospital, including its Medical Staff members, and all Third Parties, shall be exempt to the fullest extent permitted by law from liability to a Practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a Representative concerning a Practitioner.

14.5 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

(a) applications for appointment, reappointment, Clinical Privileges, practice privileges and prerogatives and periodic reappraisals of a Practitioner's membership, privileges and/or prerogatives.

(b) corrective action.

(c) hearings and appellate reviews.

(d) Hospital, Service, Committee, or other Medical Staff activities related to monitoring, maintaining and improving the quality of patient care, appropriate utilization and appropriate professional conduct.

(e) professional review organization and like reports.

14.6 RELEASES

Each Practitioner, upon request of the Hospital, shall execute general and specific releases in accordance with the provisions, tenor and import of this Article. Execution of such releases shall not, however, be deemed a prerequisite to the effectiveness of this Article.

ARTICLE XV:
GENERAL PROVISIONS

15.1 RULES AND REGULATIONS

15.1-1 MEDICAL STAFF RULES AND REGULATIONS

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Board. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Practitioner in the Hospital. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present, without previous notice or at any special meeting on proper notice, by a majority vote of the Active Medical Staff members present. Such changes shall become effective only after approval by the Governing Board, which approval shall not be unreasonably withheld. If a conflict arises between the Bylaws and the Rules and Regulations, the Bylaws shall prevail.

15.1-2 DEPARTMENT RULES AND REGULATIONS

Subject to the approval of the Medical Executive Committee or the Medical Staff and the Governing Board, each Department shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these Bylaws, the general rules and regulations of the Medical Staff, or other policies of the Hospital.

15.2 PROFESSIONAL LIABILITY INSURANCE

Each Practitioner shall be required, as a prior condition of initial appointment and reappointment and/or the granting or continued exercise of privileges, to present a current certificate of insurance, from an insurance company licensed or approved by the Commissioner of Insurance to do business in the State of Iowa, verifying professional liability insurance coverage of at least $1,000,000 per claim or medical incident. Each member shall report any reduction, restriction, cancellation or termination of the required professional liability insurance coverage or change in insurance carrier as soon as reasonably practical to do so to the CEO and the Medical Executive Committee.

15.3 CONSTRUCTION OF TERMS AND HEADINGS

The captions or 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.

15.4 AUTHORITY TO ACT

Action of the Medical Staff in relation to any person other than the members thereof shall be expressed only through the President or the Medical Executive Committee or his or her or its designee, and they shall first confer with the CEO prior to taking any such action. Any member

or members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee, the Medical Staff or Governing Board may deem necessary.

15.5 ACCEPTANCE OF PRINCIPLES

All members of whatever class or category, by application for membership in this Medical Staff, do thereby agree to be bound by the provisions of these Bylaws as they now exist and as they may be amended from time to time, a copy of which shall be delivered or made available to each member on his or her initial appointment and throughout the duration of his or her membership on the Staff. Any violation of these Bylaws shall subject the applicant or member to such disciplinary action as the Medical Executive Committee or Governing Board shall direct. Notwithstanding the foregoing, nothing in these Bylaws or in the Rules and Regulations is intended to create, or shall be deemed to create, a contract for employment or otherwise, between the Hospital and any member of the Medical Staff or any other Practitioner.

15.6 DIVISION OF FEES

The practice of the division of professional fees, or "fee-splitting", under any guise whatsoever is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff. It shall be understood, however, that a compensation arrangement involving payment by a group practice of the salary of a physician member of the group practice does not constitute an unlawful division of fees.

15.7 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests and other communications required or permitted to be served on or given to a party or parties by another, pursuant to these Bylaws, shall be in writing and shall be delivered personally or by United States Postal Service, first-class postage prepaid, certified or registered, return receipt requested. In the case of notice to the Hospital, Governing Board, Medical Staff or officers of Committee thereof, the notice shall be addressed as follows:

Waverly Health Center
312 9th Street SW
Waverly, Iowa 50677

In the case of a notice to a Practitioner or other party, the notice shall be addressed to the address as it appears in the records of the Hospital. If personally delivered, such notice shall be effective upon delivery and if mailed as provided for above, such notice shall be effective two days after it is placed in the mail. Any party may change its address as indicated above, by giving written notice of such change to the other party in the manner as above indicated.

15.8 SECRET WRITTEN MAIL BALLOT

Whenever these Bylaws shall require voting by secret written mail ballot, the mail ballot shall be returned in an unmarked envelope, which shall be placed inside a properly identified return

envelope on which the Staff member has printed and signed his or her name. The Staff member's name shall be verified against the Medical Staff records.

15.9 CONFLICTS

In the event of conflicting or inconsistent provisions in the Medical Staff Bylaws and the Rules and Regulations, the Bylaws shall control. In the event of conflicting or inconsistent provisions in the Medical Staff Bylaws and the Hospital Bylaws, the Hospital Bylaws shall control. In the event of conflicting or inconsistent provisions in the Medical Staff Bylaws and any written contract with a Practitioner, member of the Medical Staff or other person, the contract shall control.

15.10 WAIVER

The Hospital Governing Board may, after considering the recommendations of the Medical Executive Committee and any appropriate department chairs, waive any of the requirements for Medical Staff membership and Clinical Privileges or any other requirement or procedure established pursuant to these Bylaws or the rules and regulations of the Medical Staff or any department or division for good cause shown if the Governing Board determines that such waiver is necessary to meet the needs of the Hospital and the community it serves. The refusal of the Governing Board to waive any requirement shall not entitle any practitioner to a hearing or any other rights of review. The waiver of any provision hereunder shall not be deemed a future waiver of such provision.

15.11 PROCEDURES NOT PERMITTED TO BE PERFORMED

The Board of Trustees may at any time after considering the recommendation of the Medical Executive Committee direct that specific procedures or clinical practices not be performed at the Hospital if the governing Board determines that such practices or procedures are not medically acceptable, cannot be properly performed at the Hospital, are inconsistent with the mission, operations or principles of the Hospital, or for any other reason determines that the procedures or services should not be performed in the Hospital. There shall be no appeal or hearing with regard to any decision by the Governing Board that any practices or procedures are not permitted to be performed in the Hospital.

15.12 TIME PERIODS

All time periods referred to in these Bylaws, for action by committees or panels of the Medical Staff, the Hospital President/CEO, or the Governing Board, and references to meetings at which action should be taken by them, are advisory only and not mandatory. While no such actions shall be required to be accomplished in less time than that specified, extensions may be granted or permitted for reasonable cause or the convenience of participants. Time periods within which individual Practitioners are permitted to request a Hearing or an Appellate Review, or to take other action, are intended to impose mandatory limitations and shall be strictly construed absent agreement to the contrary. Any time period set forth in these Bylaws may be changed by agreement of all of the parties affected.

15.13 NATIONAL PRACTITIONER DATABANK REPORTING

Federal law sets forth the requirements for the Hospital to make reports to the National Practitioner Databank. The Hospital shall make reports to the National Practitioner Databank as required by law, and also may make reports as the Hospital determines to be in the best interest of patient care.

ARTICLE XVI:
ADOPTION AND AMENDMENT OF BYLAWS

16.1-1 INITIATED BY MEDICAL STAFF

Proposed amendments to these bylaws may be originated by the MEC or by a petition signed by twenty-five percent (25**%)** of the members of the Active category of the Medical Staff.

16.1-2 ADOPTION OF AMENDMENTS:

There must be 2 affirmative votes prior to final Board approval. The proposed amendment will be first considered by the MEC and if approved, will be sent to the General Medical Staff to consider.

16.1-3 REVIEW AND VOTE TO AMEND BYLAWS BY MEC:

All active members of the Medical Staff shall receive at least fourteen (14) days advance notice of the proposed changes prior to date the MEC will review and vote on the changes.

The amendment shall be voted on at a regular meeting or a special meeting of the MEC. To be approved, the changes must receive an affirmative vote by a simple majority of the MEC.

If approved, the proposed amendment will be placed on the General Medical Staff meeting agenda for consideration.

16.1-4 REVIEW AND VOTE TO AMEND BYLAWS BY GENERAL MEDICAL STAFF:

All active members of the Medical Staff shall receive at least fourteen (14) days advance notice of the proposed changes prior to date the General Medical Staff wi ll review and vote on the changes.

16.2 INITIATED BY GOVERNING BOARD

If these Bylaws are not in compliance with the requirements imposed by law, regulation, order of court of law, for accreditation, for tax purposes, or otherwise reasonably necessary for the effective and efficient operation of the Hospital, the Governing Board may request appropriate amendment. The Medical Staff shall take action on that amendment at its next regular meeting, following notice to all members which includes the exact wording of the existing Bylaw language, if any, and the proposed change(s). If sanctions will be imposed upon the Hospital in the absence of amendment prior to the next regular meeting, a special meeting of the Medical Staff shall be called within a reasonable time to take action. The same notice shall be sent to all members prior to the

special meeting. The proposed amendment shall be deemed adopted by the Medical Staff unless the Medical Staff takes action that amends these Bylaws at an earlier special meeting.

16.3 ACTION ON BYLAW CHANGE

If a quorum is present for the purpose of enacting a Bylaw change, the change shall require an affirmative vote of two-thirds of the members voting in person or by written ballot.

16.4 APPROVAL

Bylaws changes adopted by the Medical Staff shall become effective following approval by the Governing Board. If the Governing Board does not take action within 90 days, the amendment will be considered to have been automatically approved.

Neither the MEC, General Medical Staff, or Governing Body can unilaterally change the Bylaws.

16.5 EXCLUSIVITY

The method described in Section 16 will be the only method for the initiation, adoption, amendment or repeal of the Medical Staff Bylaws.

BYLAWS REVISIONS:

VERSION	REVISION SUMMARY:	MEC Approval Date	Med Staff Approval Date	Governing Board Approval Date
2.1	**New Version Medical Staff Bylaws**	---	06/15/09 08/17/09	09/28/09
2.2	Revisions to sections: 4.6-2, 4.6-3, 13.5(a)(b), 6.4-8	Discussed 10/18/10; no action.	10/18/10 12/20/10	01/24/11
2.3	Revisions to sections: 3.5(p), 6.4-6	Discussed 02/20/12; no action.	02/20/12 04/15/12	04/23/12
2.4	Revisions to section: 7.6	10/15/12	12/17/12	01/28/13
2.5	Section 12.2 – Midlevel on MEC / Proposed 04/15/13	Not Approved		
2.6	Revisions to sections: 6.2-1(a), 6.4-5, 10.1-4, 12.3-1.	11/17/14 01/19/15	02/15/15	02/26/15
2.7	Addition of Ancillary Category	06/15/15	06/15/15	08/31/15
2.8	Addition of Affiliate Staff / Proposed 3/21/16	Not Approved		
2.9	Revisions to sections: Definitions – 6, 3.2-2, 3.5, 4.2-1, 4.2-3(d), 4.3-1(b), 4.3-2(a), 4.4-1(b), 4.4-2(c), 4.5-1(a)(b), 4.7-2(b), 4.8-1, 4.8-2(b), 5.1, 6.3-2, 6.3-3, 6.3-8(b), 6.4-5, 6.4-6, 7.3-1, 7.3-2, 7.4-2(a), 7.5, 7.6(b), 7.7, 8.1-1(b), 8.3-1(c), 8.3-2, 8.3-4, 10.1-3, 12.4, 12.5, 12.6-2, 12-8, 12.9-1, 12-10, 13.1-2, 13.1-3(a), 13.5-1(a)(c), Article XVI .	04/17/17	04/17/17	04/24/17
3.0	Revisions to sections: 4.6-1, 4.6-2	08/20/18	10/15/18	10/22/18
3.1	Revisions to sections 6.4-1, 12-3.1	09/17/18	10/15/18	10/22/18
3.2	Revisions to section 4.7-1 and 4.7-2	10/15/2018	10/15/18	10/22/18
3.3	Revisions to section 4.2-3	12/17/18	12/17/18	01/29/2019