

Community Hospital

The logo for Community Hospital features the name in a white serif font on a dark blue rounded rectangular background. Below the text is a horizontal bar with segments of blue, orange, green, and purple.

**BYLAWS
OF THE
COMMUNITY HOSPITAL
MEDICAL STAFF**

DEFINITIONS

Chief Executive Officer or **CEO** means the individual appointed by the Governing Board as the chief executive officer to act on its behalf in the overall executive and administrative management of the Hospital. The CEO may, consistent with his responsibilities under the bylaws of the Hospital, designate a representative to perform his responsibilities under these Medical Staff Bylaws and related manuals.

Clinical Privileges or **Privileges** means the permission granted by the Governing Board to a Practitioner to provide those diagnostic, therapeutic, medical, or surgical services specifically delineated to the Practitioner.

Community Hospital or **Hospital** means Colorado West Healthcare System, d/b/a Community Hospital located in Grand Junction, Colorado, and shall include First Choice Same Day Surgery Center.

Corporate ByLaws means the bylaws of Colorado West Healthcare system.

Dentist means an individual with a D.D.S. or D.M.D. degree who is licensed or otherwise authorized to practice dentistry in the State of Colorado.

Department Chair means the individual elected pursuant to the Medical Staff Bylaws to serve as the chairman of a clinical department.

Doctor of Osteopathy means an individual with a D.O. degree who has graduated from an accredited school of osteopathy who is licensed in the state of CO and who has successfully completed a post graduate residency program.

Governing Board or **Board** means the governing body of the Hospital, or, as appropriate to the context, any committee or individual authorized by the Governing Board to act on its behalf on certain matters.

Medical Doctor means an individual with an M.D. degree who has graduated from an accredited school of medicine, who is licensed in the state of CO and who has successfully completed a post graduate residency program.

Medical Executive Committee or **MEC** means the executive committee of the Medical Staff that shall constitute the governing body of the Medical Staff as described in these Bylaws.

Medical Staff or **Staff** means all Physicians/Practitioners who are appointed to membership and are granted clinical privileges by the Governing Board to admit and care for patients or to provide other diagnostic, therapeutic, teaching or research services at the Hospital.

Medical Staff Bylaws or **Bylaws** means the Bylaws of the Community Hospital Medical Staff.

Oral Surgeon means an individual with a D.D.S. or D.M.D. degree who is licensed or otherwise authorized to practice dentistry in the State of Colorado and who has successfully completed a postgraduate program in oral and maxillofacial surgery.

Physician means an individual with a D.O., D.P.M., or M.D. degree, who is licensed or otherwise authorized to practice medicine in the State of Colorado.

Podiatrist means an individual that has graduated from a podiatry school approved by the Colorado Board of Podiatry who is fully licensed or otherwise authorized to practice podiatry in Colorado.

Practitioner means, unless otherwise expressly limited, any appropriately licensed Physician, Dentist, Oral Surgeon, Podiatrist, or psychologist applying for or granted Clinical Privileges in the Hospital.

Psychologist is an individual who has graduated from an accredited school with a degree in psychology and who is licensed to practice in the state of Colorado.

ARTICLE I

PURPOSE OF THE MEDICAL STAFF BYLAWS

Section 1.01 Purpose.

The purpose of the Medical Staff Bylaws is:

- A. To organize the activities of qualified Physicians and other clinical Practitioners who practice at the Hospital to carry out certain functions delegated to the Medical Staff by the Board pursuant to these Bylaws.
- B. To provide guidelines for the conduct of and processes relating to Practitioners who have applied for or been granted Medical Staff appointment or Clinical Privileges by the Board.
- C. To provide criteria and a process for the application, credentialing and privileging of Practitioners.
- D. To provide a structure for monitoring the effectiveness of patient care and to participate in utilization review, quality assessment, and performance improvement activities.
- E. To outline processes for corrective action, hearings, and appellate review.
- F. To provide an organization, when appropriate, that facilitates teaching, training and instruction to Medical Staff members, medical students, and Hospital personnel.
- G. To provide a structure for accountability and communication to Hospital administration and Governing Board.
- H. To promote quality care and treatment for all patients regardless of their ability to pay.

Section 1.02 Responsibilities of the Medical Staff.

The Medical Staff is accountable to the Governing Board for the quality and efficiency of patient care rendered in the Hospital by Practitioners granted clinical privileges at the Hospital through the following measures:

- A. Review and evaluation of the quality of patient care and utilization of Hospital facilities and resources through quality assessment and utilization review programs.
- B. Provision of mechanisms that allow ongoing professional practice evaluations.
- C. Provision of a credentials program, including mechanisms for appointment, reappointment, and delineation of Clinical Privileges to be exercised based upon the verified credentials, current demonstrated performance of and other information the Hospital and/or its Medical Staff deem relevant regarding an applicant or Medical Staff appointee.

- D. Provision of a continuing education program fashioned at least in part on needs demonstrated through quality review and evaluation programs.
- E. Making reports and/or recommendations as required by the Governing Board or under these Medical Staff Bylaws, to the Governing Board with respect to appointment, reappointment, staff category and Clinical Privileges, of appointees to the Hospital's Medical Staff.
- F. Making recommendations to the Governing Board regarding programs with respect to professional guidelines for the delivery of health care within the Hospital.
- G. Initiating, investigating and making reports and/or recommendations as required by the Governing Board or under these Medical Staff Bylaws regarding corrective action with respect to Medical Staff members and other individuals granted Clinical Privileges at the Hospital.
- H. Developing, administering, recommending, making amendments to and enforcing these Medical Staff Bylaws and the regulations, guidelines, and requirements of the Hospital and/or its Medical Staff.
- I. Assisting in identification of community health needs, in setting appropriate institutional goals, and in implementation of programs to meet those needs.
- J. Exercising the authority delegated by the Governing Board under these Medical Staff Bylaws as necessary to adequately fulfill the foregoing responsibilities.

ARTICLE II

MEDICAL STAFF APPOINTMENT

Section 2.01 Criteria for Membership.

- A. Membership on the Medical Staff of Community Hospital is a privilege which shall be extended only to professionally competent Physicians, Podiatrists, Dentists, Oral Surgeons, and psychologists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws including demonstration through documentation and/or primary source verification of the background, experience, training, current competence, knowledge, judgment, ability to perform, technique and professional level of quality and efficiency necessary to perform in his or her specialty for all Clinical Privileges requested.
- B. All new Medical Staff members shall be Specialty Board Certified or be in the process of obtaining qualification for certification and must obtain such Specialty Board Certification from the American Board of Medical Specialties, American Osteopathic Association, the American Board of Podiatric Surgery, or the Dental Specialties Certifying Boards by the end of the fifth year following completion of a Practitioner's residency or fellowship training, whichever is later.

- C. Upon request, provide evidence of physical and/or mental health that does not impair the fulfillment of his or her responsibilities of Medical Staff membership or the ability to exercise the Clinical Privileges requested or granted to an applicant.
- D. Maintain appropriate personal qualifications, including consistent observance of legal, ethical and professional standards. These standards include, without limitation, a history of consistently acting in a professional, appropriate and collegial manner with others in clinical and professional settings and a history of not engaging in disruptive conduct or conduct that creates a hostile environment.
- E. Demonstrate the capability to provide continuous care to patients of the Practitioner receiving inpatient or outpatient services from the Hospital under the direction of the Practitioner.

Section 2.02 Medical Staff Membership or Clinical Privileges Not a Right.

No Practitioner shall be entitled to membership on the Medical Staff or to Clinical Privileges merely by virtue of licensure or certification, membership in any professional organizations, or clinical privileges at any other healthcare organization or at the Hospital.

Section 2.03 Qualifications.

Before an application may be processed, all applicants for appointment and reappointment to the Medical Staff must provide evidence of the following qualifications for Medical Staff membership and Clinical Privileges, unless the Governing Board allows a specific exemption after consultation with the MEC:

- A. Demonstration of successful graduation from an approved school of osteopathy, medicine, dentistry, podiatry, or other professional education program appropriate to the clinical specialty of the applicant. Psychologists must demonstrate successful graduation from an approved program in psychology and hold certifications for any stated specialties.
- B. A current unrestricted license as a Practitioner required for the practice of his or her profession within the state of Colorado, or otherwise authorized to practice as a Practitioner in Colorado pursuant to Colorado law.
- C. Possession by a Physician and by a Practitioner other than a Physician, if applicable, of a current, valid, unrestricted United States Drug Enforcement Agency (DEA) certificate.
- D. Demonstration within the last 12 months of recent clinical performance and competence in an active clinical practice in the clinical practice area or discipline in which Clinical Privileges are sought, or demonstration of a plan for reentry into active clinical practice which plan must be acceptable to and approved by the Governing Board.
- E. Evidence of skills to provide a type of service that the Governing Board has determined to be appropriate for performance within the Hospital and for which the Governing Board has determined that a need exists.

- F. Evidence of professional liability insurance of a type and in an amount established by the Governing Board.
- G. A record that is free from past or current sanctions, penalties, settlements, consent decrees or agreements, or integrity agreements by or with Medicare, Medicaid, Tricare or any other federal or state governmental payor or agency. The applicant may not be listed on the Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals/Entities ("Exclusion List").
- H. A civil or criminal record that is free of any convictions, pleas of guilty, no contest or nolo contendere to felonies or to misdemeanors involving moral turpitude or occurrences that would raise questions of undesirable conduct.
- I. A Physician applicant must have successfully completed an allopathic or osteopathic residency program of at least two years, approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association ("AOA"), and must be currently Specialty Board certified or Specialty Board admissible by an approved board of the American Board of Medical Specialties ("ABMS") or the AOA in the specialty of application.
- J. Dentists must have graduated from an American Dental Association ("ADA")-approved school of dentistry accredited by the Commission of Dental Accreditation ("CDA").
- K. Oral and maxillofacial surgeons must have graduated from an ADA-approved school of dentistry accredited by the CDA, have successfully completed an ADA-approved residency program, and be Specialty Board certified or Specialty Board admissible by the American Board of Oral and Maxillofacial Surgery.
- L. A podiatric Physician must have successfully completed a two-year residency program in surgical, orthopedic, or podiatric surgery/medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association, and be Specialty Board certified or Specialty Board qualified by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedic and Primary Podiatric Medicine, or American Board of Medical Specialties in Podiatry.

Section 2.04 Request for Application.

Requests for applications for appointment to the Hospital Medical Staff and requests for Clinical Privileges will be directed to and processed through the Hospital's Medical Staff Office ("Medical Staff Office"). The Medical Staff Office will then provide the applicant with an application packet, a copy of the Medical Staff Bylaws, a copy of the Medical Staff rules and regulations, and a copy of the Code of Ethics and Conduct as well as performance expectations as adopted by the Medical Staff (any of which may be provided in paper or electronic form). If for any reason the applicant does not meet the expectations or criteria outlined in the application packet, the application will not be processed.

Section 2.05 Completed Application.

- A. The completed application shall include:
1. A completed, signed and dated Colorado Health Care Professionals Application in the form adopted by the Governing Board.
 2. A completed Privilege delineation form.
 3. Copies of all documents and information necessary to confirm that the applicant meets the criteria and qualifications for Medical Staff membership and/or Clinical Privileges including any requested additional documentation.
 4. Application fees.
 5. A government issued photo identification.
 6. A list of at least three peers who can support the applicant's ability, experience, and competence to perform the requested Privileges. A peer is defined to be a Practitioner in the same professional discipline as the applicant who is not a member of the applicant's current private practice group or the private practice group the applicant is joining.
 7. A statement from the applicant supporting the applicant's physical and mental health and ability to perform the responsibilities and Privileges requested.
 8. Clinical outcome data as available.
- B. An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional or clarifying information in the course of reviewing the application. An incomplete application will not be processed.

Section 2.06 Appointment Process and Procedure.

- A. The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the Medical Staff Office receives all required supporting documents verifying information on the application and providing sufficient evidence, as required at the sole discretion of the Hospital or the MEC, that the applicant meets the requirements for Medical Staff membership and the Privileges requested. If information is missing from the application—or if new, additional, or clarifying information is required—a letter requesting such information will be sent to the applicant. If the requested information is not returned to the Medical Staff Office within 45 days of the receipt of the request letter, it will be deemed a voluntary withdrawal of the application and the applicant will not be entitled to a hearing or appeal as provided in these Bylaws.
- B. Upon receipt of a completed application as defined above, the applicant will be sent a letter of acknowledgment by the Medical Staff Office. Individuals seeking appointment and reappointment shall have the burden of producing any additional information and

participating in any additional evaluation deemed necessary by the Hospital or the MEC for a proper evaluation of current competence, character, ethics, behavior, and other qualifications, and for resolving any doubts.

- C. Any applicant not meeting the minimum requirements for membership on the Medical Staff, as set forth in these Bylaws, will not have his or her application processed and will not be entitled to a hearing or appeal as provided in these Bylaws.
- D. Upon receipt of a completed application, the Medical Staff Office will verify its contents from acceptable sources and collect additional information as follows:
 - 1. In person verification of a government issued photo identification.
 - 2. Information from all prior and current liability insurance carriers concerning claims, suits, settlements, and judgments (if any) during the past 10 years.
 - 3. Documentation of the applicant's past clinical work experience.
 - 4. Licensure status in all current or past states where the applicant has held a license.
 - 5. Verification of the completion of professional training programs, including residency and fellowship programs.
 - 6. Information from the AMA or AOA Physician Profile, Federation of State Medical Boards, Exclusion List, Fraud and Abuse Control Information System, or other such data banks.
 - 7. Information from the National Practitioner Data Bank.
 - 8. Information available from the Colorado Board of Medical Examiners pursuant to the Michael Skolnick Medical Transparency Act.
 - 9. Other information about adverse credentialing and privileging decisions
 - 10. One or more peer recommendations from Practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, ethical character, and ability to work with others.
 - 11. Additional information as may be requested to ensure applicant meets the criteria for Medical Staff membership and/or requested Privileges.
 - 12. If available, the results of any drug test and/or other physical or mental health testing required by a healthcare institution or licensing board.
 - 13. Information from a criminal background check.

Section 2.07 Medical Staff Evaluation and Recommendation/Report.

- A. The Medical Staff, through its designated committees and officers, shall investigate and consider each application for appointment to the Medical Staff. The Hospital shall not discriminate in granting Staff appointments and/or Clinical Privileges on the basis of age, sex, race, creed, color, nationality or any other legally impermissible basis. The Hospital shall endeavor to complete the Medical Staff appointment process within 180 days of receipt by the Medical Staff Office of a completed application. This processing period may be extended by the time required for an applicant to produce any additional requested documentation or to undergo any additional requested examinations. Failure of the Hospital to complete the appointment process within 180 days shall not create any right on the part of an applicant to Medical Staff membership or to be granted Clinical Privileges.
1. Departmental review. Upon receipt of a completed and verified application, the Department Chairman or his designee or a department committee will review the application and supporting documentation. As soon as practicable after the department's review, the Department Chairman or his designee shall submit to the Credentials Committee a report regarding the applicant's qualifications, training and experience and whether the applicant meets the requirements and qualifications established by the Hospital for Medical Staff appointment and Clinical Privileges.
 2. Credentials Committee Report. The Credentials Committee shall review the application, the supporting documentation and such other information available to it that it deems relevant to consideration of the applicant's qualifications for Medical Staff category and Clinical Privileges. The Credentials Committee shall then transmit a report to the MEC that states whether the applicant meets the qualifications and requirements established by the Hospital for Medical Staff appointment, Staff category, department affiliation, and Clinical Privileges requested by the applicant.
 3. MEC Action. After receipt of the Credentials Committee report, the department's report, the completed application and all other information and documentation it deems relevant, the MEC shall consider such application, reports, documentation and information. Once the MEC's review of the application and supporting documentation and information is complete, the MEC shall forward to Hospital administration for transmittal to the Board, a written report and recommendations, as to Medical Staff appointment, Staff category, department affiliation and Clinical Privileges to be granted and any special conditions to be attached to or considered in the final decision regarding appointment.
- B. At any level of review above, additional information, verification, and/or an interview with the applicant may be requested. The review of the application may be stayed until such additional information and / or verification is received. All appointments to the Medical Staff shall be made by the Governing Board and shall be for a term of two years and become effective upon the date of vote by the Governing Board. If the Board

appoints the applicant, the notice to appoint shall include the Staff category, the department to which the Practitioner is assigned, the Clinical Privileges approved for such applicant, and any special conditions attached to the appointment.

- C. If the Governing Board's decision is to deny the application, in whole or in part, the notice to the applicant shall also include:
 - 1. A general statement of the reasons for denial.
 - 2. A summary of the applicant's hearing rights as set forth in these Bylaws, unless the applicant has previously exercised or been deemed to have previously waived the procedural rights provided in these Bylaws.
- D. The Governing Board shall also notify the MEC of any decision by the Board to deny, in whole or in part, an applicant's application for Medical Staff membership or Clinical Privileges.

Section 2.08 Focused Professional Practice Evaluation

- A. After the granting of Clinical Privileges, each Practitioner shall be monitored according to the Medical Staff Focused Professional Practice Evaluation (FPPE) policy. The Department Chair or committee will determine the type and duration of monitoring which may include prospective, concurrent, or retrospective monitoring such as but not limited to:
 - 1. chart review
 - 2. tracking performance monitors/indicators
 - 3. external peer review
 - 4. simulations
 - 5. morbidity and mortality reviews
 - 6. discussion with other healthcare providers involved in patient care
- B. FPPE may also be instituted when questions arise from the Peer Review Committee or when Clinical Privileges for new treatments or procedures are requested.

Section 2.09 Reappointment Process.

- A. An application for reappointment shall be sent to a current Staff member by the Medical Staff Office on or before 90 days prior to the date a Medical Staff member's appointment will expire. Each Staff member who desires reappointment shall submit an application for reappointment to the Medical Staff office no less than 60 days prior to such expiration of Staff appointment and/or Clinical Privileges.

Failure to submit an application for reappointment in a timely fashion shall be deemed a voluntary resignation from the Staff and of Clinical Privileges effective at the expiration of the Staff member's then current appointment. A Practitioner whose appointment and Clinical Privileges so expire shall be deemed to have waived and shall not be entitled to the procedural rights provided in these Bylaws.

- B. The following information may be collected during the reappointment process:
1. A summary of clinical activity at the Hospital for each Medical Staff member due for reappointment.
 2. Performance and conduct in this Hospital and other hospitals (where available) in which a Practitioner has provided substantial clinical care since the last appointment or reappointment, including, without limitation, patterns of care as demonstrated in findings of quality assessment/performance improvement activities, his or her clinical judgment and skills in the treatment of patients, and his or her behavior and cooperation with Hospital personnel, patients, and visitors.
 3. Evidence of the required hours, if any, of Category 1 continuing medical education activities.
 4. Service on Medical Staff, department, and Hospital committees.
 5. Timely and accurate completion of medical records.
 6. Compliance with all applicable Bylaws, policies, rules, regulations, and procedures of the Hospital and Medical Staff.
 7. Any gaps in employment or practice since the previous appointment or reappointment.
 8. A peer recommendation when insufficient peer review data are available to evaluate current competence, ethical character, and ability to work with others.
 9. Malpractice history for the past two years from a primary source verified by the malpractice carrier(s).
 10. Investigations, sanctions, restrictions or limitations, whether voluntarily or involuntarily imposed or initiated by any health care entity, peer review or quality assessment activity or by any federal or state agency.
 11. Information from the Exclusion List, the National Practitioner Data Bank and the Colorado Board of Medical Examiners pursuant to the Michael Skolnick Medical Transparency Act.
- C. It is the policy of the Hospital to approve for reappointment only those individuals who have been determined by the MEC to be providers of effective care that is consistent with Hospital standards of ongoing quality as determined by the MEC and the Hospital. Medical Staff members with less than two years of residency training are grandfathered and considered compliant in the reappointment process.

Section 2.10 Responsibilities of Members.

- A. Each member of the Medical Staff shall abide by the laws and code of ethics applicable to his profession.
- B. Each member of the Medical Staff and all Practitioners who have been granted clinical privileges under these Bylaws shall:
 - 1. Provide his or her patients with care in conformity with the standards of his or her profession and at a level of quality and efficiency acceptable to the Hospital.
 - 2. Maintain current knowledge in the management and control of pain and particularly end of life comfort care.
 - 3. Abide by the Hospital and Medical Staff Bylaws, rules and regulations, policies and procedures, and all other lawful standards.
 - 4. Prepare and complete in a timely fashion the medical and other records for all patients the Practitioner admits, or in any way provides care to, in accordance with the Hospital or Medical Staff policies, procedures, regulations, and rules pertaining to medical records.
 - 5. Recognize and acknowledge his or her responsibility to cooperate with and assist the Hospital in its fiscal administration and to comply with those regulations and guidelines as imposed by third party payers and others as they may be further defined by the MEC or the Board.
 - 6. Inform the chairman of the Credentials Committee and immediately report to the Medical Staff Office any change in status, either pending or completed, of the Practitioner's professional license; state or federal DEA controlled substances registrations; professional liability insurance coverage; membership/employment status or clinical privileges in other institutions, facilities, or organizations; mental or physical health which might impair the Practitioner's ability to perform professional or Medical Staff duties; any change in status of current or initiation of new malpractice claims; exclusion from Medicare, a Medicaid program or any other federal or state healthcare program; or the initiation of an investigation by any federal, state or local agency.
 - 7. Respond to requests for initial and reappointment application material and attachments as delineated in the credentialing and privileging manual and as required by these Bylaws.
 - 8. Provide notice to the Hospital CEO regarding personal conviction of, or a plea of guilty to, no contest or nolo contendere to a felony or misdemeanor involving moral turpitude.

9. Each member of the Medical Staff shall maintain and demonstrate evidence of sufficient professional liability insurance in such amounts and including such terms as the Board shall from time to time specify.

Section 2.11 Conflicts of Interest.

If outside activities, relationships, or personal interests influence or appear to influence the Practitioner's decisions in the course of providing quality care, a conflict of interest may occur. Such conflicts may include, without limitation, decisions that may result in personal profit or gain, treatment options where the Practitioner or a member of the Practitioner's immediate family directly or indirectly are involved in a competing or complimentary business, or outside activities that hinder or distract the Practitioner from the performance of the Practitioner's responsibility to provide quality care and call coverage.

These relationships as well as relationships with educational institutions, manufacturers, distributors and payers shall be disclosed in writing annually to the Medical Staff Office on the proper Hospital form.

Section 2.12 Management of Interpersonal Conflict (Conflict Resolution).

- A. Should questions arise or there is reason to doubt the safety, quality, or timeliness of medical care, or a difference of opinion exists either from a nurse or other Hospital employee, or from a Practitioner regarding care rendered or omitted, the following steps may be taken toward resolution:
 1. A civil person to person discussion of the issue in question.
 2. Further resolution may be sought from the supervisor/director of the respective department of the Hospital or the Department Chair of the Medical Staff department.
 3. When indicated the unresolved concern may be raised with the president of the Medical Staff, the Chief Nursing Officer, Chief Medical Officer or the CEO.
 4. Final resolution shall be the responsibility of the Governing Board after recommendation by the MEC.

ARTICLE III

CATEGORIES OF THE MEDICAL STAFF

Section 3.01 Active Staff.

The Active Staff shall include Practitioners who utilize the Hospital for those patients under their care requiring inpatient or outpatient admission to the Hospital or other clinical services provided by the Hospital. To be eligible for membership, a Practitioner must demonstrate a willingness to contribute actively to the Medical Staff and to the Hospital by participating in performance improvement and peer review activities; fulfilling attendance requirements; providing emergency

care and call coverage when required; engaging in the teaching and continuing education programs of the Medical Staff; be located reasonably close to the Hospital to provide timely and continuous care to patients; and to pay Medical Staff dues as determined by the MEC and as ratified by the general Medical Staff. Members of the Active Staff shall be eligible to exercise such Clinical Privileges as are granted to him or her by the Governing Board, hold Medical Staff offices, serve on Medical Staff and Hospital committees and/or multidisciplinary teams, and vote at meetings of the Medical Staff. Members of the Active staff who are over the age of 65 shall not be required to pay annual dues. Active Staff members who have not utilized the Hospital inpatient or outpatient services for patients under their care for any consecutive two-year period must demonstrate a need for continuation of Medical Staff membership and Clinical Privileges at their next reappointment.

Section 3.02 Courtesy Staff.

The Courtesy Staff shall include Practitioners, otherwise qualified for Active Staff membership who are given privileges to admit, operate upon, or treat an occasional patient at the Hospital or to provide medical consultation on request of a Practitioner. Members of the Courtesy Staff shall not be eligible to hold Medical Staff office, serve on Medical Staff or Hospital committees and/or multidisciplinary teams. Courtesy Staff members shall pay Medical Staff dues. Courtesy Staff members will be expected to achieve, in a timely manner, Active Staff membership in some Hospital or healthcare network where they actively participate in a patient care monitoring program and other continuous improvement activities similar to those required of the Active Staff. Exceptions to this requirement may be allowed upon affirmative vote of the MEC. Courtesy Staff members who have not utilized the Hospital inpatient or outpatient services for patients under their care for any consecutive two-year period must demonstrate a need for continuation of Medical Staff membership and Clinical Privileges at their next reappointment.

Section 3.03 Honorary Staff.

The Honorary Staff shall consist of Physicians recognized for their outstanding reputation, their noteworthy contributions to the health and medical sciences, or their previous long standing service to the Hospital. They are not eligible to admit patients to the Hospital or to exercise Clinical Privileges in the Hospital. They may, however, attend Medical Staff meetings and any Staff or Hospital education meetings. Honorary Staff members are not recredentialed and are not required to maintain Colorado licensure, federal DEA certification, or Specialty Board certification. Honorary Staff members shall not be eligible to vote or hold office in the Medical Staff organization.

ARTICLE IV

ALLIED HEALTH PROFESSIONALS

Section 4.01 Allied Health Professionals.

Certain Allied Health Professionals (“AHP’s”) may be granted Clinical Privileges by the Hospital without appointment to the Medical Staff. Only AHP’s holding a license, certificate, or other legal credentials as required by Colorado law may apply to provide services in the

Hospital. AHP's shall be considered based on appropriate training, education, current competence, experience, personal character, judgment, ability to perform, professional and collegial behavior and absence of a history of disruptive behavior or creation of a hostile environment. AHP's may attend all relevant Medical Staff meetings, may not vote or hold office, and shall pay dues.

A. Allied Health Professionals eligible to be granted Clinical Privileges include:

1. Physician assistants.
2. Advanced practice registered nurses.
 - a. Nurse midwives.
 - b. Nurse practitioners.
 - c. Nurse anesthetists.
 - d. Clinical nurse specialists.

B. Application for approval or reapproval of Clinical Privileges by an AHP shall be made to the Medical Staff Office. All policies and procedures for AHP's and Clinical Privileges granted to AHP's must be reviewed and approved by the Chairperson of the clinical department in which the AHP is granted Clinical Privileges. If the AHP is a nurse practicing in an advance practice role, all Clinical Privileges must also be approved by the Hospital's Chief Nursing Officer. To be eligible to apply for Clinical Privileges, an AHP must:

1. Be a graduate of a recognized, accredited school in his or her discipline.
2. Be legally qualified to practice in the given discipline in the State of Colorado.
3. Demonstrate the ability to work well with Hospital employees and other members of the Medical Staff.
4. Have demonstrated clinical competence, ability (both mentally and physically), and judgment to perform all Clinical Privileges requested.
5. Be without a history of disruptive behavior or creation of a hostile environment.
6. Meet the specific qualifications and requirements established by the Hospital.
7. Demonstrate the required professional liability insurance coverage.
8. Abide by the Hospital's bylaws, rules and regulations, and policies applicable to the provision of care rendered by the AHP in the hospital.
9. Abide by the ethical principles of their respective profession.

- C. AHP's are expected to:
 - 1. Complete in a timely fashion the medical record, but only to the extent permitted by the AHP's legal authority to practice his or her discipline.
 - 2. Report any investigation initiated by any federal, state or local agency.
 - 3. Report any action taken by any authority or health care facility affecting authority to practice his or her discipline or DEA registration including any voluntary or involuntary relinquishment of privileges at any healthcare institution.

- D. AHP's must be assigned to or be an employee of a Medical Staff member who shall serve as a supervisor/collaborator/sponsor as required by Colorado law. This supervisor/collaborator/sponsor must accept responsibility for the appropriate supervision of the AHP and must agree that the AHP will practice only within the scope of practice defined by law and the Bylaws, rules and regulations and policies of the Medical Staff and the Hospital. The AHP is subject to Medical Staff policies of FPPE and OPPE.

- E. Should the sponsoring Medical Staff member terminate his or her Medical Staff membership or in the event that the AHP's supervisor/collaborator/sponsor is no longer able to serve in that capacity as required by Colorado law, the AHP's Privileges shall terminate automatically without any right to a hearing or appeal unless an immediate replacement for such supervisor/collaborator/sponsor is identified and qualified.

Section 4.02 Suspension, Modification or Termination of AHP Privileges.

- A. Each AHP is subject to discipline and corrective action. His or her permission to provide selected clinical services may be suspended, modified, or terminated consistent with Hospital policies and procedures. If the AHP is a Hospital employee, the Hospital's existing employment policies will be applied. For all AHP's who are granted Clinical Privileges without Medical Staff membership and who are not employees of the Hospital, in the event an action is taken that is adverse to the AHP as defined below, the AHP may request an appeal provided in this Section 4.02.

- B. The following recommendations or action shall, if deemed adverse under Section C below, entitle the Practitioner to an appeal as set forth in this Section 4.02 upon timely and proper request except as noted otherwise elsewhere in these Bylaws:
 - 1. Denial or restriction of requested Clinical Privileges.
 - 2. Reduction of Clinical Privileges.
 - 3. Suspension of Clinical Privileges.
 - 4. Revocation or termination of Clinical Privileges.

- C. A recommendation or action listed in Section B above is adverse only when it has been:

1. Recommended by the MEC to the Board.
 2. Taken to the Board under circumstances in which no prior right to request an appeal exists.
 3. Is based upon the professional competence of the AHP.
- D. The CEO shall promptly give the AHP notice of an adverse recommendation or action taken pursuant to Section 4.02. The notice shall:
1. advise the AHP of the recommendation or action and of his or her right to request an appeal pursuant to the provisions of this policy;
 2. specify that the AHP has 30 days after receiving the notice to submit a request for an appeal;
 3. indicate that the right to appeal may be forfeited if the AHP fails, without good cause, to appear at the scheduled appeal;
 4. state that as a part of the appeal, the AHP involved has the right to receive an explanation of the decision made and to submit any additional information the AHP deems relevant to the review and appeal of this decision; and
 5. state that, upon completion of the appeal, the AHP involved has the right to receive a written decision from the Hospital, including a statement of the basis of the decision.
- E. The AHP has 30 days after receiving notice to file a request for an appeal. The request must be delivered to the CEO either in person or by registered mail return receipt requested or by recognized courier service with the ability to verify delivery.
- F. An AHP who fails to request an appeal within the time and in the manner specified in this Section 4.02, waives his or her right to an appeal to which he or she might otherwise have been entitled. Such a waiver applies only to the matters that were the basis for the adverse recommendation or action triggering the notice.
- G. When an AHP requests an appeal, the appeal shall consist of a single meeting attended by the AHP, the CEO and the Chief Medical Officer. During this meeting, the basis of the decision adverse to the AHP which gave rise to the appeal will be reviewed with the AHP, and the AHP will have the opportunity to present any additional information the AHP deems relevant to the review and appeal of the decision. Following this meeting, the CEO and Chief Medical Officer will make a recommendation to the Governing Board. The AHP will receive a written decision of the Hospital stating the result of the appeal and the basis of the decision.
- H. This appeal process will be the sole remedy available to a AHP who qualifies for this appeal and who experiences an adverse decision as defined in this Section 4.02.

Section 4.03 Clinical Assistants.

- A. Clinical Assistants include:
1. Dental hygienists or dental assistants.
 2. Private duty scrub technicians.
 3. Surgical technician assistants.
 4. RN first assists.
 5. Orthopedic physician assistants .
- B. Clinical Assistants must provide evidence of training, experience or academic education qualifying them for the services they provide. Their services may only be provided under the supervision of a Medical Staff member who is responsible for the performance of the Clinical Assistant. Clinical Assistant services must be within a scope of care approved by the Medical Staff and Governing Board. Clinical Assistants have no privileges and thus are not credentialed through the Medical Staff Office. The qualifications of Clinical Assistants are reviewed by the human resource department of the Hospital. No Clinical Assistant may provide services on the premises of the Hospital without the Hospital's prior approval. The Hospital's approval of a Clinical Assistant may be withdrawn at any time with or without cause. A Clinical Assistant shall have no right to a hearing or appeal as provided in these Bylaws.

ARTICLE V

STUDENTS

Section 5.01 Students

- A. Observation: Students in good standing in courses leading to a D.D.S., D.O., D.P.M., M.D., Nurse Practitioner or Physician Assistant degree at their respective professional schools in the United States may be permitted by the Hospital to observe the care and treatment rendered by members of the Medical Staff and may provide patient care under the direct and appropriate supervision of a member of the Medical Staff. Approval will be given or withheld on the basis of the student's level of preparation for activities involving private patients. If the student is attending medical school, the medical school must be accredited by the American Medical Association or the American Osteopathic Association for the medical student to be eligible to participate in a clinical experience at the Hospital.
- B. Applications: Applications by students to the Medical Staff shall require detailed information and certifications including:

1. A letter from the dean of the degreed program received by the Medical Staff Office preferably at least 30 days prior to the commencement of preceptorship certifying:
 - a. That the applicant is in good standing in the program and that the elective rotation is an approved part of the degree program.
 - b. That the applicant will be, at a minimum, covered by professional liability insurance (with limits of at least \$1 million per occurrence/\$3 million aggregate) provided to the applicant in their degree program during the elective rotation. The applicant will be expected to provide a certificate of insurance to the Hospital certifying the existence of such coverage.
 - c. The dates when the applicant will be in the Hospital during the elective rotation.
 2. Immunization record including Tuberculosis Skin Test within one year.
 3. A letter from a Medical Staff member in good standing certifying that he or she will be responsible for and supervise the student during the elective rotation.
 4. A signed acknowledgment by the student agreeing to abide by the Hospital's policies protecting the privacy of health information.
 5. Such other information as the Medical Staff or Hospital may require.
- C. Verification: Information received in the application process will be verified by the Medical Staff Office and forwarded to the appropriate department chairman for a recommendation of approval or denial. Recommendations by the Department Chairman and the Credentials Committee will be submitted to the MEC. The MEC will forward its recommendations to the Board for final approval. (To expedite the process, temporary privileges may be approved by the President of the Medical Staff and Hospital President/CEO if requested information is deemed complete.)
- D. Effective Period: Credentialing approved under this Section shall be effective only during the period of time of the elective rotation.
- E. Requirements: Students must abide by the following requirements:
1. Students must wear photo I.D. badges while in the Hospital. These badges may be obtained from the Medical Staff Office if a suitable badge from their medical school or training program is not available.
 2. The Medical Staff member supervising the student must inform and receive the consent of the patient prior to involving the student in observation or in the patient's care.

3. Students shall not document in a patient's medical records, prescribe treatment or provide any patient care except under the supervision of a member of the Medical Staff. A Medical Staff member shall cosign any medical record entry by a student within 24 hours. Nurses will not honor an order from a student in the patient medical record until the order can be verified by the Medical Staff member.
4. Students shall comply with all applicable Hospital policies and procedures.

ARTICLE VI

CLINICAL PRIVILEGES

Section 6.01 General Delineation of Privileges.

- A. Every Practitioner practicing at the Hospital by virtue of Medical Staff membership shall be entitled to exercise only those Clinical Privileges specifically granted to him or her by the Governing Board or to exercise the disaster privileges described in these Bylaws.
- B. Each initial application for Medical Staff appointment and each application for reappointment must contain a request for the specific Clinical Privileges desired by the applicant. Focused Professional Practice Evaluation will be required for all Clinical Privileges requested in an initial application for Medical Staff appointment.
- C. Requests for Clinical Privileges will be evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current competence to perform the procedures for which Privileges are requested as well as demonstrated ability and judgment. Additional factors that may be used in determining Privileges are patient-care and Hospital needs, the Hospital's capability to support the type of Privileges being requested and the availability of qualified coverage in the applicant's absence. The bases for Privileges determination to be made in connection with periodic reappointment or a requested change in Privileges must include documented clinical performance and the results of the Hospital and Medical Staff's performance-improvement activities. Privilege determinations will also be based on pertinent information from other sources, especially other institutions and healthcare settings where a Practitioner exercises Clinical Privileges.

Section 6.02 Recredentialing and/or Modification of Clinical Privileges.

- A. Periodic re-evaluation of Clinical Privileges and the addition or curtailment of Clinical Privileges may be based upon the observation of care provided, review of the records of patients treated in this Hospital or review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care.
- B. Continuing membership on the Medical Staff will only be through the reappointment process. Every practitioner may have Focused Professional Practice Evaluation imposed on any Privilege requested, including but not limited to, preceptorship (direct observation of patient care) and/or clinical review (review of patient records) as deemed appropriate by the clinical department, Credentials Committee, or MEC.

- C. Voluntary suspension of practice while under investigation by a licensing agency will constitute a voluntary resignation from the Medical Staff.

Section 6.03 Special Privileges for Dentists, Oral Surgeons and Podiatrists.

Request for Clinical Privileges from Dentists, Oral Surgeons and Podiatrists shall be processed in the same manner as specified for other Practitioners. Dentists, Oral Surgeons and Podiatrists shall be members of and under the supervision of the Department of Surgery. Patients admitted for oral surgery or podiatric surgery may be admitted and discharged by the respective oral surgeon or podiatrist. Patients with acute or chronic medical problems and with an ASA classification of 3 or higher must be co-managed with a primary care physician, internist, or Hospitalist with Medical Staff membership and appropriate Clinical Privileges at the Hospital.

Section 6.04 Temporary Privileges.

- A. In extraordinary situations when necessary to avoid undue hardship to patients and to fulfill important patient needs, the Chief Executive Officer or Chief Medical Officer may, upon receipt of a completed application for Medical Staff appointment, after verification of training, licensure, and professional liability insurance coverage, and after querying the National Practitioner Data Bank and the Exclusion List, grant temporary Privileges to any applicant for a specific period of time, not to exceed 60 days, provided that the information available continues to support a favorable determination regarding the applicant's application for Medical Staff membership and Clinical Privileges. Temporary additional Privileges may also be granted to a current member of the Medical Staff in good standing after querying the National Practitioner Data Bank and the Exclusion List, verification of Colorado licensure, and verification of training and competence.
- B. Termination of Temporary Privileges: The CEO, acting on behalf of the Board and after consultation with the Chief Medical Officer, may terminate any or all of a Practitioner's temporary Privileges based on the discovery of any information or the occurrence of any event of a nature that raises questions about a Practitioner's Privileges. Where the life or well-being of a patient is determined to be endangered, any person entitled to impose a summary suspension under the Medical Staff Bylaws may effect the termination. In the event of any such termination, the CEO or his or her designee will assign the Practitioner's patients to another Practitioner. The wishes of the patient shall be considered, when feasible, in choosing a substitute Practitioner.
- C. Rights of the Practitioner with Temporary Privileges: A Practitioner with temporary Privileges is not entitled to the procedural rights afforded by the Investigation, Corrective Action, Hearing and Appeal procedures outlined in the Medical Staff Bylaws if his or her request for temporary Privileges is refused or his temporary Privileges are terminated.

Section 6.05 Disaster Privileges.

- A. If the Hospital's emergency management plan has been activated, the CEO and other designated individuals identified in the Hospital's emergency management plan may, on a case-by-case basis consistent with medical licensing and other relevant state statutes, grant disaster Privileges to provide patient care to selected Practitioners, provided the

Practitioner can present at least one of the following items or be personally identified and attested to by Staff members:

1. A current Hospital photo identification (ID) card.
 2. A current license to practice medicine or other professional discipline, as appropriate, accompanied by a photo identification (ID) card issued by a state, federal, or regulatory agency.
 3. Identification indicating that the individual is a member of the Disaster Medical Assistance Team, Medical Reserve Corps, Emergency System for Advance Registration of Volunteer Health Professionals, or another recognized state or federal organization or group that addresses disasters.
 4. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
 5. Identification by a current Hospital or Medical Staff member(s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent Practitioner during a disaster.
- B. The Medical Staff oversees the professional practice of volunteer licensed independent Practitioners.
- C. Primary source verification of licensure should begin as soon as the immediate situation is under control, and when possible, should be completed within 72 hours from the time the volunteer Practitioner presents to the organization. If primary source verification cannot be performed within 72 hours, the Hospital will document the following:
1. The reason primary source verification could not be performed;
 2. Evidence of a Practitioner's ability to continue to provide care; and
 3. Evidence of the Hospital's attempt to provide primary source verification as soon as reasonably possible.
- D. Once the immediate situation has passed and the determination that the disaster is over has been made consistent with the Hospital's disaster plan, the Practitioner's disaster Privileges will terminate immediately.
- E. Any individual identified in the Hospital's disaster plan with the authority to grant disaster Privileges shall also have the authority to terminate disaster Privileges. Such authority may be exercised at the sole discretion of the Hospital and will not give rise to a right to a hearing or an appeal.

Section 6.06 Expedited Credentialing Process.

- A. To more efficiently grant initial Medical Staff membership with appropriate Privileges, and to act on reappointment applications, and the renewal or modification of Privileges, the Board may delegate the authority to render those decisions to a committee of at least two voting members of the Board under the following conditions:
1. The applicant submits a complete application.
 2. The applicant has not had any adverse actions or sanctions from a state medical board.
 3. The applicant has not been reported to the National Practitioner Data Bank, is not on the Exclusion List and has no information available from the Colorado Board of Medical Examiners as a result of reporting under the Michael Skolnick Medical Transparency Act.
 4. The applicant has no more than 2 malpractice cases in the past 5 years.
 5. The applicant has no adverse references or peer review actions.
 6. The applicant has no history of limitation, reduction, denial, or loss of clinical privileges at another health care organization.
 7. The applicant's request for privileges are consistent with previous practice experience, training, and demonstrated competence.
 8. The applicant has no physical, mental, or emotional health problems that would impair the applicants ability to provide safe, quality patient care.
 9. The applicant has no history of engaging in disruptive conduct or in conduct that creates a hostile environment.
 10. The final recommendation of the MEC contains no other questions about the applicant's qualifications, ability, competence, or professionalism.

Section 6.07 Locum Tenens.

Locum Tenens Practitioners must meet the basic qualifications of Medical Staff membership and have completed the Medical Staff initial appointment or reappointment application process, as appropriate. Requests for Clinical Privileges shall be processed in the same manner as specified for other practitioners. Locum Tenens practitioners are not members of the Medical Staff and are not eligible to vote or hold Medical Staff office. They may attend Hospital educational programs and may exercise their approved Clinical Privileges for up to 120 consecutive days after which membership on the Medical Staff must be requested.

Section 6.08 Telemedicine.

The originating site (Community Hospital) is responsible for the safety and quality of services offered to its patients. Thus, all licensed Practitioners providing care, treatment and services to patients via telemedicine are subject to credentialing and privileging processes of the Hospital which may be provided in the following manner.

- A. Privileging and credentials may be accomplished using the credentialing information from the distant site as long as the distant site is a Joint Commission accredited organization.
- B. The credentialing and privileging decision of the distant site may be accepted if all the following requirements are met.
 - 1. The distant site is a Joint Commission accredited Hospital or ambulatory care organization.
 - 2. The Practitioner is privileged at the distant site for those services to be provided at the originating site.
 - 3. The originating site has evidence of an internal review of the Practitioner's performance of these privileges and sends to the distant site information that is useful to assess the Practitioner's quality of care, treatment, and service for use in privileging and performance improvement. This information includes all adverse outcomes related to sentinel events considered reviewable by the Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed practitioner from patients, licensed independent practitioners, or staff at the originating site.

Section 6.09 Leave of Absence.

- A. Initiation of Leave of Absence: A member of the Medical Staff may obtain a voluntary leave of absence from the Medical Staff by submitting written notice to the MEC stating the exact period of time for the leave, which shall not be less than three (3) months and may not exceed one (1) year. The notice must be received at least 90 days (whenever possible) prior to the proposed leave time. A leave of absence may be granted in the following circumstances:
 - 1. To undertake professional re-education or training in a related medical practice or specialization.
 - 2. Parental leave.
 - 3. For any reason deemed acceptable by the MEC.
- B. Review of the Leave of Absence: The MEC will review the request for leave and make a recommendation to the Board for final action.

- C. Refusal of Leave Request: If, for any reason, the MEC does not approve a request for a leave of absence, the Medical Staff member may appeal the decision to the Board.
1. The Board of Trustees shall hear the appeal at the earliest opportunity. The recommendation by the MEC along with the needs of the member shall be considered in the appeal meeting.
 2. The decision by the Board is final.
- D. Termination of Leave of Absence: The Medical Staff member may request reinstatement of his or her Privileges by submitting a written request to the Medical Staff Office with a written summary of all relevant activities during the leave of absence, as well as any other necessary documentation (e.g.: license, insurance, etc.) at least 45 days prior to the desired date of termination of leave. This letter will be forwarded to the Credentials Committee for verification.
- E. Verification: The Credentials Committee may request any additional information it considers relevant to evaluation of a request for reinstatement of Clinical Privileges. Failure to provide any requested additional information within 45 days of the request or prior to the scheduled end of the leave of absence, whichever occurs first, shall be treated as a voluntary resignation of Medical Staff membership and Clinical Privileges. After receipt of required documentation and verification of all information, the Credentials Committee shall make a recommendation to the MEC concerning the reinstatement of Clinical Privileges.
- F. Failure to Reinstatement: Failure to request reinstatement or to provide a requested summary of activities, without sufficient reason, shall result in automatic termination of Medical Staff membership and Clinical Privileges without the right to a hearing or appeal in accordance with these Bylaws. A request for Medical Staff membership subsequently received from the Medical Staff member so terminated shall be submitted and processed in the manner specified for an application for initial appointments.
- G. Lapse of Appointment While on Leave: If a Medical Staff member's term of appointment expires while on an approved leave of absence, the Medical Staff Office shall notify the member in writing. To regain Medical Staff appointment and Clinical Privileges, the member shall be required to initiate an application for reappointment to the Medical Staff in accordance with these Bylaws.

Section 6.10 Exclusive Contracts.

- A. When the Hospital determines to enter into a contractual relationship with a Practitioner or group of Practitioners to provide patient care services based at the Hospital, such Practitioners shall be members of the Active Medical Staff. Therefore, they must:
1. Possess the proper qualifications for Medical Staff membership and for Clinical Privileges necessary to provide the Hospital-based patient care services.

2. Submit a completed application for Medical Staff membership and Clinical Privileges to the Medical Staff Office which shall be processed according to these Bylaws.
 3. Provide patient care services that are only within the scope of the Practitioner's Privileges subject to FPPE and OPPE, as well as peer review, process improvement and actions taken by or recommended by the MEC
- B. When the Hospital elects to enter into a contract for the provision of certain clinical services on an exclusive basis, all affected Practitioners or affected individuals shall be given notice regarding the consequences the exclusive contract will have on Privileges. Should the Hospital enter into an exclusive contract after such notice, those Practitioners who have previously been granted Privileges which now are covered by an exclusive contract, will not be able to exercise those Privileges unless they are party to the exclusive contract. Furthermore, applications for appointment and/or Privileges covered by an exclusive contract will not be accepted or processed unless allowed by the exclusive contract with the Hospital.
- C. The expiration of an exclusive contract shall not in or of itself affect Medical Staff appointment or Clinical Privileges unless so governed by the terms of the exclusive contract with the Hospital.

ARTICLE VII

INVESTIGATIONS AND CORRECTIVE ACTION

Section 7.01 Investigations.

- A. Information: Any person may provide information to any member of the MEC, any member of the Governing Board, the CEO, the Chief Medical Officer or the Hospital's Chief Compliance Officer about the conduct, performance or competence of Medical Staff members. When such information is reasonably reliable and indicates that a Medical Staff member may have exhibited acts, demeanor or conduct reasonably likely to be (a) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (b) unethical; (c) contrary to the Medical Staff or Hospital Bylaws, rules and regulations; (d) contrary to Medical Staff or Hospital policies or procedures; (e) contrary to the Hospital's Compliance Plan or Code of Conduct Guide; (f) below acceptable standards of behavior including, without limitation, behavior that is disruptive or that creates a hostile environment; or (g) below applicable standards of clinical management, such information shall be submitted to the Governing Board.
- B. Initiation: Upon submission to the Governing Board, along with a description of the specific activity or activities or conduct resulting in the request for an investigation, the Chairman of the Governing Board shall determine whether the Governing Board or its designee shall initiate and conduct an investigation or whether it will delegate that determination to the MEC. If the Governing Board initiates and conducts an investigation, these Bylaws shall not apply to the conduct of such investigation nor to any

determinations or actions of the Governing Board resulting from such investigation. If the Governing Board delegates the determination to the MEC, these Bylaws shall apply to the MEC's determination and to any subsequent investigation and to any determination or actions resulting from such investigation.

- C. Investigation: If the MEC determines to initiate an investigation, it shall direct that an investigation be conducted by formal, documented action of the MEC and it shall make an appropriate record of the reasons for initiating such investigation. The record may be treated as confidential where appropriate. All determinations to initiate, not initiate or delay initiation of a requested investigation shall be reported to the Governing Board. In the event the Governing Board believes that a determination by the MEC to delay or not initiate an investigation is inappropriate, it may direct the MEC to proceed with an investigation. The MEC may conduct the investigation itself or may assign the task to an appropriate standing or ad hoc committee of the Medical Staff (the entity conducting the investigation shall be the "Investigating Body").
- D. Conduct of the Investigation: The Investigating Body shall proceed with the investigation in a prompt manner and shall develop a written or oral report of its findings, conclusions, and recommendations which report shall be presented to the MEC as soon as practicable. The Investigating Body shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate reference literature and practice guidelines, and to utilize the resources of external counsel or consultants, if deemed necessary in the sole discretion of the Investigating Body and the use of such resources is approved in advance by the Chief Medical Officer and the CEO. The Investigating Body may also require the Practitioner under investigation to undergo a physical and/or mental examination or consultation with the Colorado Physicians Health Program, or similar program, and may access the results of such examinations for consideration as part of the investigation.
- E. Notice to Practitioner: The Practitioner under investigation shall be notified that the investigation is being conducted whenever such notice will not, in the judgment of the Investigating Body, interfere with or impede the investigation, and shall be given an opportunity to provide information in a manner and upon such terms as the Investigating Body deems appropriate. This meeting (and meetings with any other individuals the Investigating Body chooses to interview) shall not constitute a hearing as that term is defined in these Bylaws, nor shall the procedural rules set forth in these Bylaws with respect to hearings and appeals apply. The Practitioner being investigated shall not have the right to be represented by legal counsel before the Investigating Body nor shall such Practitioner have the right to compel the conduct of an external consultation by the Investigating Body.
- F. Special Meeting Attendance Requirement: Whenever a Practitioner is suspected to have engaged in acts, demeanor or conduct of the type that could result in initiation of a MEC investigation, the Medical Staff President or the applicable department or committee chair may require the Practitioner to confer with him or her, or with a standing or ad hoc committee that is considering the matter. The Practitioner will be given notice of the conference at least three days prior to the conference; will be provided with the date, time

and location of the conference, and a general statement of the issue involved; and will be informed that his or her personal appearance is mandatory. The individual shall not have the right to be represented by legal counsel at the required conference. Failure of the Practitioner to personally appear at any such conference after two notices, unless excused by the MEC upon a showing of good cause, will be considered a voluntary resignation from the Medical Staff and relinquishment of Clinical Privileges effective upon failure to appear personally. The relinquishment of membership and Clinical Privileges will not give rise to a right to hearing or appeal as provided in these Bylaws. A Practitioner's voluntary resignation may be withdrawn effective upon attendance in person at a required conference within thirty (30) days of the date the Practitioner's voluntary resignation is effective. Should the Practitioner fail to withdraw the Practitioner's voluntary resignation as provided herein, the Practitioner must apply for Medical Staff membership and Clinical Privileges by completing an application for appointment and proceeding through the credentialing process for a new appointment.

- G. Subversion of Investigation: Any contact or attempt to contact the Investigating Body, the MEC or the Governing Board, or any member thereof, directly or indirectly, by the Practitioner or by another on the Practitioner's behalf outside of the investigative process in an attempt to persuade or influence the outcome of the investigation or in an attempt to persuade the Investigating Body, the MEC or the Governing Board to terminate the investigation shall result in termination of the Practitioner's Medical Staff membership and Clinical Privileges without a right to hearing or appeal as provided in these Bylaws.

ARTICLE VIII

SUSPENSION OF MEDICAL STAFF MEMBERSHIP OR CLINICAL PRIVILEGES

Section 8.01 Summary Suspension.

- A. Criteria For Initiation: Whenever a Practitioner's conduct appears to require that immediate action be taken to protect the life or well-being of a patient or patients; or to reduce a substantial likelihood of significant impairment of the life, health, safety or well-being of any person; or when the Medical Staff President, the CEO, the Chief Medical Officer, a Department Chair, or the MEC determines there is need to carefully consider any event, concern, behavior or issue that, if confirmed, has the potential to affect the safety or well-being of a patient, employee or any person on the premises of the Hospital; or the effective operation of the Hospital or any part thereof; or to impair the reputation of the Medical Staff or the Hospital, then Medical Staff President, CEO, Chief Medical Officer, a department chair, or the MEC may summarily restrict or suspend the Medical Staff membership or Clinical Privileges of such member.
- B. Effect and Duration: Unless otherwise stated, the summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly notify the CEO and the CEO shall give written notice to the Practitioner, the MEC, the Chief Medical Officer, and the Governing Board. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or,

if none, until resolved as set forth herein. The summary restriction or suspension is not a completed professional review action. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another Practitioner by the Practitioner's Department Chair or by the Chief Medical Officer.

- C. MEC Action: As soon as practicable and within fourteen (14) days after such summary restriction or suspension has become effective, a meeting of the MEC shall be convened to review and consider the summary restriction or suspension and, if deemed appropriate, initiate an investigation. Upon request and in the sole discretion of the MEC, the member may be given the opportunity to address the MEC concerning the issues giving rise to the summary restriction or suspension, on such terms and conditions as the MEC may impose. The Practitioner shall not have the right to be represented by counsel at any opportunity provided by the MEC for the Practitioner to address issues giving rise to the summary restriction or suspension. In no event shall any meeting of the MEC to consider the summary restriction or suspension, with or without the Practitioner present, constitute a hearing or give a right to an appeal as set forth in these Bylaws. The MEC may recommend modification, termination or continuation of the summary restriction or suspension and any such recommendation by the MEC regarding the summary restriction or suspension shall be communicated to the CEO and to the Governing Board. The Governing Board shall make a final determination regarding modification, termination or continuation of such summary restriction or suspension. The CEO shall provide notice of the Governing Board's determination to the Practitioner.

Section 8.02 Automatic Relinquishment, Suspension, or Limitation.

In the following instances, the Practitioner's Clinical Privileges or Medical Staff membership will be considered suspended, relinquished, or limited as described, which action shall be final without a right to hearing or appeal as provided in these Bylaws. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines the circumstances are not applicable. The MEC will make such a determination as soon as practicable. In addition to automatic relinquishment, suspension or limitation, whenever any of the following actions occur, an investigation may be initiated and/or further corrective action may be recommended in accordance with these Bylaws.

A. Licensure:

1. Revocation and suspension: Whenever a Practitioner's license or other legal credential authorizing practice in this state is voluntarily or involuntarily revoked, suspended or relinquished, Medical Staff membership and/or Clinical Privileges shall be automatically relinquished by the Practitioner as of the date such action becomes effective.
2. Restriction: Whenever a Practitioner's license or other legal credential authorizing practice in this state is voluntarily or involuntarily limited or restricted by an applicable licensing or certifying authority, any Clinical Privileges that the Practitioner has been granted at this Hospital that are within the scope of said

limitation or restriction shall be automatically limited or restricted in a manner that is consistent with limitation or restriction by an applicable licensing or certifying authority as of the date such action becomes effective and throughout its term.

3. Probation: Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, his or her membership status and/or Clinical Privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.
4. Medicare, Medicaid, Tricare or other federal or state programs: Whenever a Practitioner is sanctioned or barred from Medicare, Medicaid, Tricare, or from any other federal or state programs, Medical Staff membership and/or Clinical Privileges shall be considered automatically relinquished as of the date such action becomes effective. Any Practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her Privileges as of the effective date of exclusion.

B. Controlled substances:

1. DEA certificate: Whenever a Practitioner's United States Drug Enforcement Agency (DEA) certificate is voluntarily or involuntarily revoked, limited, or suspended, the Practitioner shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term, and the Practitioner's Clinical Privileges shall be automatically limited or restricted in a manner that is consistent with the limitation of the DEA certificate.
2. Probation: Whenever a Practitioner's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

C. Medical record completion requirements: A Practitioner will be considered to have voluntarily relinquished the Privilege to admit new patients or schedule new procedures when he or she fails to complete medical records within time frames established by the Medical Staff or the Hospital, as applicable. This relinquishment of Privileges shall not apply to patients admitted or already scheduled at the time of relinquishment or to emergency patients. The relinquished Privileges will be restored by the CEO upon a determination by the chair of the Medical Records Committee that Practitioner completed the records the Practitioner failed to complete provided that such medical records are completed in a manner that complies with medical record policies of the Medical Staff or the Hospital, as applicable. Nothing in this paragraph shall limit or restrict the consideration of failure to complete medical records as part of any Medical Staff appointment or reappointment.

- D. Professional liability insurance: Failure of a Practitioner to maintain professional liability insurance in the amount required by Medical Staff or Board policies shall result in immediate automatic relinquishment of a member's Clinical Privileges. If within 60 days of the relinquishment the Practitioner does not provide evidence of required professional liability insurance (including tail coverage for any period during which insurance was not maintained), the member shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the Medical Staff. The member must notify the Medical Staff office immediately of any change in professional liability insurance carrier or coverage.
- E. Medical Staff dues/special assessments: Failure to promptly pay Medical Staff dues or any special assessment shall be considered an automatic relinquishment of a Practitioner's Medical Staff membership and/or Clinical Privileges. If within 60 days after written warning of the delinquency the member does not remit such payments, the Practitioner shall be considered to have voluntarily resigned membership on the Medical Staff and/or Clinical Privileges effective on the 60th day after the date of such written warning.
- F. Indictment or conviction: A Practitioner who has been indicted, convicted of, or pled "guilty", "no contest", "nolo contendere" or their equivalent to a felony or to a misdemeanor involving a charge of moral turpitude in any jurisdiction shall have his or her Medical Staff membership and/or Clinical Privileges suspended automatically. Such suspension shall become effective immediately upon such indictment, conviction, or plea, regardless of whether an appeal is filed. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Governing Board or through corrective action, if necessary.
- G. Special Appearance, evaluation, Specialty Board certification
1. Failure to satisfy the special appearance requirement: A Practitioner who fails without good cause to appear at a meeting where his or her special appearance is required in accordance with the Medical Staff or the Hospital's Bylaws shall be considered a voluntary resignation from the Medical Staff and relinquishment of all Clinical Privileges. These Privileges will be restored upon compliance with the special appearance requirement as provided in these Bylaws or as provided in the Hospital's corporate bylaws.
 2. Failure to participate in an evaluation: A Practitioner who fails to participate in an evaluation of his or her qualifications for Medical Staff membership or Privileges as required under the Medical Staff or the Hospital Bylaws and as directed by the MEC, the Governing Board or an Investigating Body (whether physical and/or mental evaluation or an evaluation of clinical management skills), shall be considered to have automatically relinquished all Clinical Privileges effective upon failure to obtain such evaluation as directed.

- H. Providing False or Misleading Information. Any Practitioner who provides false or misleading information as part of a Medical Staff appointment or reappointment process shall have his or her Medical Staff membership and Clinical Privileges automatically relinquished upon discovery, irrespective of when the discovery occurs, by the Hospital or the Medical Staff of such false or misleading information.

Section 8.03 Governing Board Authority.

Nothing in these Bylaws including, without limitation, this Article VIII shall limit the authority of the Governing Board acting independently, including actions by the CEO as agent of the Governing Board, to restrict, suspend, limit, or terminate Clinical Privileges of a Practitioner and such action by the Governing Board shall not be subject to these Bylaws.

ARTICLE IX

HEARING AND APPEALS

Section 9.01 Initiation and Notice of Hearing.

- A. Initiation of hearing: An applicant or member of the Medical Staff shall be entitled to request a hearing whenever an action adversely affecting the member's Medical Staff membership or Clinical Privileges and subject to these Bylaws is proposed by the MEC except where otherwise noted in these Bylaws. No applicant or Medical Staff member shall be entitled to more than one hearing with respect to the subject matter of any proposed adverse recommendation or action that gives rise to a hearing right. Hearings will be offered only when the MEC recommends taking one of the following actions based on a concern about competence or professional conduct:
1. Denial of Medical Staff reappointment.
 2. Denial or revocation of Medical Staff appointment.
 3. Denial, restriction or reduction of requested Clinical Privileges.
 4. Involuntary reduction, restriction, revocation or suspension of Clinical Privileges that is for longer than 30 consecutive days.
 5. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement applies only to an individual Medical Staff member and is applied for more than 30 consecutive days.
 6. Suspension of Staff appointment or Clinical Privileges, but only if such suspension is for more than 30 consecutive days and is caused by the member's clinical competence or professional conduct.

B. Events that will not create an obligation to offer a hearing: Notwithstanding the preceding section, the following will not create an obligation to offer a hearing to the affected Practitioner:

1. Issuance of a letter of guidance, warning, or reprimand.
2. Imposition of a requirement for proctoring (i.e., observation of the Practitioner's performance by a peer in order to provide information to a Medical Staff committee) with no restriction on Privileges.
3. Failure to process a request for a Privilege when the applicant/member does not meet the eligibility criteria to hold that Privilege.
4. Conduct of an investigation into any matter or the appointment of an ad hoc investigation committee.
5. Requirement to appear for a special meeting or to provide information under the provisions of these Bylaws.
6. Automatic relinquishment or voluntary resignation of Medical Staff appointment or Privileges including, without limitation, automatic relinquishment for subversion of an investigation.
7. Imposition of a summary suspension that does not exceed 30 days.
8. Denial of a request for leave of absence, or for an extension of a leave.
9. Determination that an application is incomplete or untimely.
10. Determination that an application will not be processed due to misstatement or omission.
11. Decision not to expedite an application.
12. Termination or limitation of temporary Privileges.
13. Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership.
14. Ineligibility to request membership or Privileges or continue Privileges because a relevant specialty is closed under a Medical Staff development plan or covered under an exclusive provider agreement.
15. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted or if exhaustion of due process rights are pending.
16. Termination of any contract with or employment by the Hospital.

17. Proctoring, monitoring, and any other performance monitoring requirements imposed during any provisional period imposed under these Bylaws or in order to fulfill Joint Commission standards on Focused Professional Practice Evaluation.
18. Any recommendation voluntarily accepted by the member.
19. Expiration of membership and Privileges as a result of failure to submit an application for reappointment within the allowable time period.
20. Change in assigned staff category.
21. Refusal of the credentials committee or MEC to consider a request for appointment, reappointment, or Privileges within one year of a final adverse decision regarding such request.
22. Removal or limitation of emergency department call obligations.
23. Any requirement to complete an educational or clinical competence assessment.
24. Retrospective chart review.
25. Any requirement to complete a health and/or psychiatric/psychological or other assessment as provided under these Bylaws.
26. Grant of conditional appointment or appointment for a limited duration.
27. Appointment or reappointment for a duration of less than 24 months.
28. Any action taken by the Governing Board that is not subject to these Bylaws.

C. Notice and request for a hearing.

1. When a recommendation is made which entitles an applicant or a member of the Medical Staff to a hearing prior to a final decision by the Board, the affected applicant or Medical Staff member shall be given prompt notice by the CEO, in writing, return receipt requested. Such notice shall contain:
 - a. A statement of the recommendation made and the general reason for such recommendation;
 - b. A statement that the individual has a right to request a hearing on the recommendation within 30 days of the date on the return receipt for this notice; and
 - c. A copy of the Medical Staff Bylaws.
2. The affected applicant or Medical Staff member shall have 30 days from the date on the return receipt for such notice to request a hearing. The request for a hearing shall be made by notice to the CEO, in writing, return receipt requested.

- D. Waiver of right to a hearing: The failure of any applicant or Medical Staff member to request a hearing to which he or she is entitled in the manner and within the timeframe required in these Bylaws shall be deemed a waiver of the right to such a hearing and to any appellate review. When a hearing right is waived, the MEC's adverse recommendation to the Governing Board will be considered final, and the Governing Board will take final action on the recommendation.
- E. Notice of hearing and statement of reasons: The CEO shall schedule the hearing and shall give written notice, certified mail return receipt requested or by courier service providing verification of delivery, to the person who requested the hearing. The notice shall include the following:
1. The time, date, and location of the hearing.
 2. A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence in support of the MEC at the hearing.
 3. The names of the hearing panel members and presiding officer or hearing officer, if known.
 4. A statement of the specific reasons for the recommendation, as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing, provided that the additional material is relevant to the continued Medical Staff appointment or Clinical Privileges of the individual requesting the hearing, and provided that the individual has reasonably sufficient time to study this additional information in preparation for the hearing.

The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties.

Section 9.02 Hearing Panel Composition: Hearing Panel, Chairperson or Presiding Officer, Hearing Officer.

- A. Hearing panel:
1. When a hearing is requested, the CEO, acting for the Board and after considering the recommendations of the Medical Staff President (and those of the chairperson of the Board, if the hearing is occasioned by a Board determination), shall appoint a hearing panel that shall be composed of not fewer than three members. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. Employment by, or a contract with, the Hospital or an affiliate shall not preclude any individual from serving on the hearing panel. Hearing panel members need not be members of the Medical Staff. When the issue before the panel is a question of clinical competence, all

panel members shall be clinical Practitioners. Panel members need not be Practitioners in the same specialty as the member requesting the hearing.

2. The hearing panel shall not include any individual who is in direct economic competition with the affected person or any such individual who is professionally associated with or related to the affected individual. This restriction on appointment shall include any individual designated as the chairperson or the presiding officer.
3. The CEO or designee shall notify the Practitioner requesting the hearing of the names of the panel members and the date by which the Practitioner must object, if at all, to appointment of any member(s). Any objection to any member of the hearing panel or to the hearing officer or presiding officer shall be made in writing to the CEO, who shall determine whether a replacement panel member should be identified. While the Practitioner who is the subject of the hearing may object to a panel member, he or she is not entitled to veto that member's participation. Final authority to appoint panel members will rest with the CEO.

B. Hearing panel chairperson or presiding officer:

1. In lieu of a hearing panel chairperson, the CEO and Medical Staff President may appoint an attorney at law or other individual experienced in due process as presiding officer. Such presiding officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendation.
2. If no presiding officer has been appointed, a chairperson of the hearing panel shall be appointed by the CEO to serve as the presiding officer and shall be entitled to one vote.
3. The presiding officer (or hearing panel chair) shall do the following:
 - a. Act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process
 - b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay
 - c. Maintain decorum throughout the hearing
 - d. Determine the order of procedure throughout the hearing

- e. Have the authority and discretion, in accordance with this policy, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence
- f. Act in such a way that all information reasonably relevant to the continued appointment or Clinical Privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations
- g. Conduct argument by counsel on procedural points and may do so outside the presence of the hearing panel
- h. Seek legal counsel when he or she feels it is appropriate. Legal counsel to the Hospital may advise the presiding officer or panel chair.

C. Hearing officer:

- 1. As an alternative to the hearing panel described in Section 9.02 of these Bylaws, the CEO, after consulting with the Medical Staff President (and chair of the Board if the hearing was occasioned by a Board determination) may appoint a hearing officer to perform the functions that would otherwise be carried out by a hearing panel. The hearing officer may be an attorney.
- 2. The hearing officer may not be any individual who is in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a hearing officer is appointed instead of a hearing panel, all references in this Article to the “hearing panel” or “presiding officer” shall be deemed to refer instead to the hearing officer, unless the context would clearly require otherwise.

D. Burden of proof: The hearing panel shall recommend in favor of the MEC (or the Board) unless it finds that the individual who requested the hearing has proved by a preponderance of the evidence that the recommendation that prompted the hearing was arbitrary, capricious, or unsupported by credible evidence. It is this individual’s burden to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and Clinical Privileges.

E. Relevant evidence at hearing: The hearing officer, presiding officer, and/or panel shall allow the parties to present witnesses to testify to relevant evidence only. “Relevant evidence” means evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence. The hearing officer or hearing panel chair shall have complete discretion to determine what evidence is relevant. In general, the peer review records of other members of the Medical Staff will not be considered relevant or admissible. The hearing officer, presiding officer, and/or panel shall not be obligated to follow formal rules of evidence.

F. Role of attorneys: Attorneys representing the Hospital and the Practitioner who has requested the hearing may be present at the hearing, advise their client, and participate in

resolving procedural matters. Attorneys may not introduce evidence, including, but not limited to, examining or cross-examining witnesses.

Section 9.03 Appeals to the Board.

- A. Time for appeal: Either the Physician or the MEC may appeal the recommendation within 10 days after delivery of notice of the hearing panel's recommendation. The request for appellate review shall be in writing and shall be delivered to the CEO either in person, by certified mail, return receipt requested or by courier service providing verification of delivery, and shall include a brief statement of the reasons for appeal and the specific facts or circumstances that justify further review. If such appellate review is not requested within 10 days as provided herein, both parties shall be deemed to have accepted the recommendation involved, and the hearing panel's report and recommendation shall be forwarded to the Board for final action.
- B. Grounds for appeal: The grounds for appeal shall be limited to the following:
1. There was substantial failure to comply with the hearing plan set forth in the Medical Staff Bylaws prior to the hearing so as to deny a fair hearing
 2. The recommendation of the hearing panel was made arbitrarily, capriciously, or was unsupported by credible evidence
 3. The recommendation of the hearing panel was not supported by a preponderance of the evidence based upon the hearing record
- C. Time, place, and notice: Whenever an appeal is requested as set forth in the preceding sections, the chairperson of the Governing Board shall schedule and arrange for an appellate review as soon as arrangements can be reasonably made, taking into account the schedules of all individuals involved. The affected individual shall be given notice of the time, place, and date of the appellate review. The chair of the Governing Board for good cause may extend the time for appellate review.
- D. Nature of appellate review:
1. The chair of the Governing Board shall appoint a review panel composed of not fewer than three members of the Governing Board to consider the information upon which the recommendation before the Board was made. Members of the review panel may not be direct economic competitors of the Practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.
 2. The review panel may, but is not required to, accept additional oral or written evidence subject to the same cross-examination and admissibility provisions adopted at the hearing panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied.

3. Each party shall have the right to present a written statement in support of its position on appeal. At its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited 30-minute oral argument. The review panel shall recommend final action to the Governing Board.
 4. The Governing Board may affirm, modify, or reverse the recommendation of the review panel or, at its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Governing Board's ultimate legal responsibility for the Hospital.
- E. Final decision of the Board: Within 30 days after receipt of the review panel's recommendation, the Governing Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected individual and to the chairpersons of the Credentials Committee and MEC either in person, by certified mail, return receipt requested or by courier service able to verify delivery. The final decision of the Governing Board following the appeal shall be effective immediately and shall not be subject to further review.
- F. Right to one appeal only: No applicant or Medical Staff member shall be entitled as a matter of right to more than one hearing or appellate review on any single matter that may be the subject of a hearing or appeal. In the event that the Governing Board ultimately determines to deny Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or Clinical Privileges of a current Practitioner, that individual may not apply within five years for Medical Staff appointment or for those Clinical Privileges at the Hospital unless the Governing Board provides otherwise.

ARTICLE X

OFFICERS OF THE MEDICAL STAFF

Section 10.01 Identification

- A. The officers of the medical staff shall be:
1. President.
 2. President Elect.
 3. Immediate Past President.

Section 10.02 Qualifications.

Officers must be members of the Active Medical Staff in good standing at the time of nomination and election. They must remain a member of the Active Staff in good standing during the term of office. Previous leadership as a department or committee chairman at this Hospital is preferred.

Section 10.03 Election of Officers.

Officers shall be elected at the annual meeting of the Medical Staff by vote of the Active members of the Medical Staff. They shall serve a term of 3 years without the possibility of reelection.

Section 10.04 Nominations.

The MEC shall select at least four members of the Active Medical Staff to serve as the Nominating Committee. The Nominating Committee must have equal representation of primary care physicians and specialists.

- A. The Nominating Committee shall be selected no later than 60 days prior to the date of an election.
- B. The Nominating Committee shall present a list of candidates to the Active Medical Staff at least 30 days prior to the date of an election. The slate of candidates to be developed by the Nominating Committee shall consist of nominations of individuals to serve as Medical Staff officers, Department Chairmen, Medical Staff members to serve on the Credentials Committee, and Medical Staff members to serve on the Governing Board.
- C. Additional nominations shall be accepted from any Medical Staff member in writing no later than 20 days prior to the date of an election.
- D. Nominations shall not be made from the floor.

Section 10.05 Vacancies.

Vacancies in office during the Medical Staff year, except for the President, shall be filled by appointment made by the MEC. If there is a vacancy in the office of the President of the Medical Staff, the President Elect shall serve the remaining term of the President.

Section 10.06 Duties of Officers.

- A. President of the Medical Staff: The President of the Medical Staff shall serve as the administrative officer of the Medical Staff and:
 - 1. Act in coordination and cooperation with the President/CEO and the Chief Medical Officer in all matters of mutual concern with the Hospital.
 - 2. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.
 - 3. Serve as chairman of the MEC without vote.
 - 4. Appoint committee members and designate chairpersons to all standing, special, and multi-disciplinary Medical Staff committees except the MEC.

5. Represent the views, policies, needs, and grievances of the Medical Staff to the Governing Board and the President/CEO. The President of the Medical Staff shall be a voting member of the Governing Board.
 6. Receive and interpret the policies of the Governing Board to the Medical Staff.
 7. Report to the Governing Board with respect to the Medical Staff's delegated responsibility to provide quality, effective care within the Hospital.
 8. Be a spokesman for the Medical Staff in its external professional matters and public relations.
 9. Be responsible for the enforcement of the Medical Staff Bylaws and rules & regulations for implementation of corrective action where indicated and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested regarding a Practitioner.
 10. Work in concert with the chairman of the Medical Education Committee to ensure adequate educational activities for the Medical Staff.
- B. President Elect: In the absence of the President of the Medical Staff, the President Elect shall assume all the duties and have the authority of the President of the Medical Staff. Except when acting as the President of the Medical Staff, the President Elect shall be a voting member of the MEC. The President Elect shall automatically succeed the President of the Medical Staff when the latter fails to serve for any reason. If the President Elect completes the partial term of his predecessor, he will be eligible for a 3 year term in addition to the partial term of his predecessor.
- C. Immediate Past President: The Immediate Past President shall act in an advisory capacity and be a voting member of the MEC.

Section 10.07 Medical Staff Members Serving on the Governing Board.

The MEC shall recommend members of the Active Medical Staff to serve a three (3) year term on the Governing Board with the option to serve a second three (3) year term. Medical Staff members serving on the Governing Board pursuant to this Section shall be selected for their ability to represent the interests of the Hospital and the Medical Staff as a whole. They shall also be selected so that there will be two (2) primary care and two (2) specialty physicians as voting members on the Governing Board at all times. Nominees shall be nominated by the Medical Staff Nominating Committee and recommended to the Governing Board by the MEC. Nominees may not be employed by Colorado West Healthcare System or any of its affiliated or subsidiary entities or organizations.

Section 10.08 Chief Medical Officer.

The Chief Medical Officer shall be employed by the Hospital and shall serve as the chief quality officer and clinical officer for the Medical Staff to:

- A. Direct the development, implementation and day-to-day functioning and organization of the Medical Staff components of the quality, risk, and utilization programs, overseeing that they are clinically and professionally sound and accomplishing their objectives and in compliance with the standards of accrediting agencies.
- B. Supervise the clinical organization of the Medical Staff, coordinate the delivery of services among the clinical services, and assist the President/CEO in personnel and services with Medical Staff clinical units.
- C. Advise the Board, the President/CEO and MEC on matters having an effect on patient care and clinical services, including the need for new or modified programs and services, for recruitment and training of professional and support staff and personnel and for staffing patterns.
- D. Serve as chairman of the Peer Review Committee, be a member of Critical Care Committee, and be responsible for mortality review.
- E. Serve as co-chairman of the Credentials Committee.
- F. Co-manage the MEC agenda.

Section 10.09 Removal of Officers.

Any ten (10) members of the Active Medical Staff may request in writing the removal for cause of any officer, Department Chairman, Committee Chairman or member of the MEC. Conditions for removal of such individuals may include, but are not limited to: failure to fulfill responsibilities, malfeasance while in office, conduct detrimental to the interests of the Hospital and/or the Medical Staff, failure of an officer to maintain membership in good standing in the Active Medical Staff, failure to satisfy criteria and qualifications for Medical Staff membership and/or conflict of interest. After due consultation with the affected officer or member, the MEC, with a two-thirds majority vote of all MEC members, and without the need for prior request for removal by 10 members of the Active Medical Staff, may remove any officer of the Medical Staff, Department Chairman, Committee Chairman or member of the MEC. If the decision of the MEC to remove the officer or individual is challenged by 30 members of the Active Medical Staff who have requested in writing that the decision of the MEC to remove an officer or individual be presented to the entire Medical Staff, the MEC decision will be presented to the entire Active Medical Staff. To be effective, such requests from all 30 members of the Active Medical Staff must be received by the Medical Staff office within 30 days of the effective date of the action by the MEC to remove an officer or individual. Following presentation to the full Medical Staff, the Medical Staff Office shall cause a secret ballot to be conducted of the entire Active Medical Staff. A three-fourths majority vote of the entire Active Medical Staff shall be required to overturn the decision of the MEC.

Section 10.10 Succession of Duties.

There shall be a successive list of individuals who shall assume the administrative functions for the President of the Medical Staff in the order listed:

- A. President Elect.
- B. Immediate Past President.
- C. Chairman of the Credentials Committee.

There shall be a successive list of individuals who shall assume the administrative functions of the President Elect in the order listed:

- A. Chairman of the Credentials Committee.
- B. Department Chairman of the President Elect's department.

ARTICLE XI

CLINICAL DEPARTMENTS

Section 11.01 Organization.

The medical staff shall be organized into departments as follows:

- A. Current Departments:
 - 1. Medicine.
 - 2. Surgery.
- B. Future Departments: The MEC may, upon approval of the Board, create new, eliminate, subdivide, or combine departments.

Section 11.02 Assignment to Clinical Departments.

Each member of the Medical Staff shall be assigned membership and/or Clinical Privileges in one or more departments and be subject to the Medical Staff Bylaws, policies and procedures, rules and regulations, and requirements of the Hospital and/or its Medical Staff as well as be subject to the rules and regulations and policies of such department and to the authority of the Department Chairman in each department in which the Staff appointee exercises Clinical Privileges.

Section 11.03 Functions of Clinical Departments.

- A. Meet at least quarterly to conduct business.
- B. Establish guidelines for the granting of Clinical Privileges within the department and the reports required under these Bylaws regarding appointment and the Clinical Privileges that each Staff appointee or applicant may exercise.
- C. Maintain appropriate standards of care through case review and evaluation, trending of quality indicators and provide for ongoing continuing education.

- D. Assist and participate in comprehensive evaluation of a Practitioner's practice through focused and/or ongoing professional practice evaluation.
- E. Monitor, on a continuing basis, adherence to:
 - 1. Bylaws, policies, procedures, rules, regulations, guidelines and requirements of the Hospital and its Medical Staff.
 - 2. Call and consultative responsibility by maintaining, reviewing and managing a current and active call schedule.
 - 3. Clinical practice protocols and standards.
- F. Coordinate the patient care provided by the department members with nursing, ancillary patient care services and with administrative support services as needed.
- G. Maintain records of its activities.

Section 11.04 Department Chairperson.

Each clinical department of the Medical Staff shall have a Department Chairman who is elected by the Medical Staff and has the authority, duties, and responsibilities as delineated below. Election will be held at the annual Medical Staff meeting, and the chairman will be elected by a majority vote of the Active Medical Staff members present.

- A. Qualifications: Each clinical Department Chairman shall be a member of the Active Medical Staff in good standing and qualified by training, experience, and demonstrated ability for the position. He or she shall be willing to discharge faithfully the functions of the Department Chairman and possess written and oral communication skills and ability for harmonious interpersonal relationships. The clinical Department Chairman shall be Board Certified (or in process of Board certification) by an appropriate specialty Board.
- B. Term of Office: Each clinical Department Chairman shall serve for one (1) year until the next annual Medical Staff meeting. A Department Chairman may succeed himself for no more than three (3) consecutive one-year terms.
- C. Responsibilities:
 - 1. Participate on a continuous basis in managing the department through cooperation and coordination with nursing and other patient care services, Hospital management, and the President of the Medical Staff on all matters affecting patient care.
 - 2. Organize and preside at all departmental meetings and conferences either in person or through his designee.
 - 3. Designate an Active Medical Staff member from his own department as temporary chairman if for any reason he is to be absent for more than 2 weeks.

This appointee will have all the responsibility of the chairman until the chairman returns. If the chairman of the department is unable to appoint a designee, the President of the Medical Staff will make such appointment. The Department Chairman shall notify the Medical Staff Office in writing of such designation in advance of his absence.

4. Recommend to the Medical Staff the criteria for clinical privileges in the department.
5. Prepare and transmit recommendations concerning appointment, reappointment, delineation of Clinical Privileges or specified services, and corrective action with respect to Physicians/Practitioners or Allied Health Professionals holding membership or exercising Privileges or services in the department.
6. Assure the maintenance of quality control programs as appropriate.

ARTICLE XII

COMMITTEES AND COMMITTEE FUNCTION

Section 12.01 Designation and Substitution.

There shall be a MEC, standing medical staff committees, multi-disciplinary standing committees, and such special committees as may from time to time be necessary and desirable to perform the duties of the Medical Staff and the Hospital. The MEC may establish ad hoc committees to perform one or more Medical Staff functions.

Section 12.02 Appointments.

Committee members, except MEC members, will be appointed by the President of the Medical Staff, in consultation with the Department Chairmen and the President/CEO and the Chief Medical Officer. The administrative staff appointees shall serve as ex-officio members, with or without vote as provided in the provisions or resolution creating the committee.

Section 12.03 Medical Staff Committees with Peer Review Activity and Protection.

A. Medical Executive Committee:

1. Composition:

The MEC shall consist of the following voting members:

- a. President (Non-voting member except to break a tie vote) who shall serve as chair.
- b. President Elect.
- c. Immediate Past President.

- d. Chairmen of each clinical department.
- e. Two members providing representation from hospital based groups to include emergency physicians, anesthesiology, radiology, pathology, and hospitalists.
- f. Family Practice representative.
- g. IM Representation

Ex-officio non-voting members shall include:

- a. President/CEO.
- b. Chief Medical Officer.
- c. A non-Medical Staff member of the Board of Trustees.

2. Meetings: The MEC shall meet at least ten times per year and shall maintain a permanent record of its proceedings and actions.

3. Functions:

- a. Governance, Direction and Coordination.
 - (1) Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by the Bylaws.
 - (2) Receive, coordinate and act upon reports and recommendations from the departments, committees and officers of the Staff concerning the patient care evaluation and performance improvement activities.
 - (3) Account to the Board and to the Medical Staff for the overall quality and efficiency of patient care in the Hospital.
 - (4) Coordinate the activities of and the policies adopted by the Staff, departments and committees.
 - (5) Implement policies of the Medical Staff not otherwise the responsibility of the departments.
 - (6) Make recommendations to the Governing Board regarding medico-administrative, hospital planning and hospital management matters when necessary.
 - (7) Take responsible steps to ensure professionally ethical conduct and clinical performance on the part of Staff members including

initiating and conducting investigations and initiating and pursuing corrective action, when appropriate.

- (8) Provide liaison between the Medical Staff, the President/CEO, and the Board.
- (9) Ensure participation in continuing education programs that inform the Medical Staff of significant new developments and new skills in medicine.
- (10) Report at general meetings of the Medical Staff.
- (11) Investigate any breach of ethics for the resolution of conflict in patient care and treatment issues.
- (12) Make recommendation to the Board relative to Clinical Privileges and Medical Staff membership.

b. Bylaws Review and Revision.

- (1) Ensure that there is review of the Medical Staff Bylaws and Rules and Regulations at least every two years.
- (2) Submit written recommendations for amendments to the Bylaws, in accordance with provisions of Article XVI.

c. Nominating.

- (1) Follow the nominating process in accordance with Section 10.04.

d. Library.

- (1) Ensure that library holdings and internet access/programs are appropriate, current and adequate, and recommend acquisitions as necessary.
- (2) Assist the Medical Librarian or other designated individual in charge of the professional library to establish rules and regulations for use of the Medical Library.

e. Continuing Medical Education.

- (1) Cooperate with the Education Committee Chairman to ensure that educational programs, relevant to the type of patient care delivered in the Hospital, are developed and meet requirements for continuing education. Such programs to be, in part, related to the findings of Performance Improvement activities.

- (2) Ensure that continuing education recommendations from the Staff or other committees responsible for other quality review, evaluation and monitoring functions are carried out.
- (3) Ensure that periodic notices of medical education activities are presented to the Medical Staff.
- (4) Ensure that training programs for medical students are implemented and evaluated in coordination with the GMEC.
- (5) Ensure that medical students are directly supervised by the Medical Staff and are compliant with the quality of care standards of Community Hospital in accordance with Article V, Section 5.01.

f. Other Functions/Committees.

- (1) The Medical Staff is responsible for other review functions, which shall be reported to and acted upon by the Medical Executive Committee. These review functions may be carried out through formal committees of the Medical Staff, or through other mechanisms. The Medical Executive Committee may from time to time appoint new committees, eliminate or combine committees, to ensure the effectiveness of the review functions.

4. Terms: Unless otherwise specifically provided, a MEC member shall continue as such until the end of his period of appointment and until his successor is elected or appointed, unless he shall sooner resign or be removed from the committee. Elected representatives of physician groups will serve a one (1) year term with the option of up to two (2) additional terms. Ex-officio members of the MEC shall serve a term concurrent with the term of the office by virtue of which appointment to the MEC was made.

B. Credentials Committee:

1. Composition: The Credentials Committee shall consist of:
 - a. Three members of the Active Staff (ensuring representation from the specialties of Medicine and Surgery) serving three (3) year terms each.
 - b. The Chief Medical Officer.
2. Chairman: The Chairman shall be the President Elect or appointed by the President of the Medical Staff. Members of the Credentials Committee may serve a three (3) year term and not be eligible for reappointment to the committee for a period of one (1) year.

3. Meetings: The Credentials Committee shall meet at least ten (10) times a year and shall maintain a permanent record of its proceedings and actions. The meetings will occur prior to scheduled MEC meetings.
4. Functions:
 - a. Review the credentials of all applicants and make recommendations for membership and delineation of Clinical Privileges in compliance with these Bylaws.
 - b. Report to the MEC on each applicant requesting Medical Staff membership or clinical privileges, including specific consideration of the recommendations from the chairman of the department in which such applicant requests privileges.
 - c. Review periodically all information available regarding the performance of Staff members and as a result of such reviews, make recommendations for the granting of Privileges, reappointments and the assignment of Physicians/Practitioners to the various departments or services as provided in Articles II of these bylaws.
 - d. Report any breach of ethics to the MEC.
 - e. All Medical Staff reappointments require a recommendation by the department chairman and/or peer.

C. Peer Review Committee:

1. Membership: The Peer Review Committee (“PRC”) will be chaired by the Chief Medical Officer who shall be a non-voting member. The committee will be comprised of two surgeons/anesthesiologist; two primary care physicians; one physician at large, and one internal medicine physician. Meetings will be at the call of the chairman on an as needed basis. Members will serve a term of three years.
2. Committee Function: The PRC will review and evaluate the professional conduct and quality and appropriateness of patient care provided by Physicians and will provide the process where quality, risk management issues and patient safety issues will be evaluated. The PRC will notify the Physician being reviewed by phone, certified letter or email of the issues being reviewed and solicit his input. Final decisions and recommendations will be given in writing to the Physician and to the Credentials Committee and MEC. The process will function as outlined in the peer review process policy.

D. Osteopathic Methods and Concepts Committee:

1. Composition: The members of this Committee shall consist of at least three (3) osteopathic physicians on the Active Medical Staff; and, if possible, one (1) osteopathic physician from each of the organized departments.
2. Meetings: The Osteopathic Methods and Concepts Committee meeting will be held at least quarterly and a permanent record will be maintained of proceedings and actions.
3. Functions: The functions of the Committee shall include:
 - a. Recommendations to improve utilization of osteopathic principles and practice, to record osteopathic findings, describe osteopathic manipulative treatment and to apply such modalities as part of the comprehensive care received by patient-guests.
 - b. Establishing and recording retrospective and current audits of patient-guest charts relating the application of osteopathic principles and practice to patient-guest diagnosis and treatment.
 - c. Informing osteopathic physicians of the evaluations of patient-guest charts done by the committee to improve utilization of osteopathic principles and practices.

E. Interdisciplinary Hospital Committees: Medical staff functions and responsibilities relating to liaison with the Board, Administration, or Hospital regarding accreditation, disaster planning, quality and appropriateness of care, process improvement, risk management and compliance shall be accomplished by interdisciplinary hospital committees.

These interdisciplinary hospital committees may be appointed by Hospital Administration and/or the President of the Medical Staff to perform one or more of the Staff functions set forth in these Bylaws and other bylaws, policies, procedures, rules, regulations, guidelines, and requirements of the Hospital and its Medical Staff. Members of the committees may include but not be limited to Medical Staff members, representatives of Hospital Administration, nursing service, medical records service, pharmaceutical service, social service, laboratory and radiology services and other department members as Hospital Administration or the President deem appropriate to the functions to be discharged.

Medical staff participation shall include, but not be limited to the following:

1. Medical Records Committee.
 - a. Review and constructively criticize current medical records.
 - b. Ensure the maintenance of medical records at an acceptable standard of completeness.

- c. Submit written reports to the MEC at its scheduled meetings.
 - d. Recommend any new use or any change in the format of medical records.
 - e. Recommend policies for medical record maintenance and supervise medical records to ensure proper recording of sufficient data to evaluate patient care.
2. Pharmacy and Therapeutics Committee.
- a. Formulate drug policies and establish pharmacy procedures.
 - b. Develop a Hospital formulary or list of drugs for use in the Hospital and to amend the formulary as needed and practical.
 - c. Evaluate clinical data concerning new drugs requested for use in the Hospital.
 - d. Help formulate broad policies on evaluation, selection, procurement, distribution, and use of drugs.
3. Infection Control.
- a. Develop an infection control plan for the Hospital.
 - b. Provide guidelines to prevent and control the spread of infection to employees, patients, visitors, and others within the institution.
 - c. Review and revise, if necessary, the Hospital's infection control plan.
 - d. Furnish written reports to the Medical Staff of activities and findings.

ARTICLE XIII

MEETINGS

Section 13.01 General Staff Meetings.

Meetings of the entire medical staff shall be held at least biannually to consider and act upon amendments to the Bylaws, to receive information on the activities of the Hospital, to improve Hospital services and to educate the Medical Staff. At the winter General Staff meeting, election of officers and department chairman will occur. The General Staff meetings may be a combined social event/business meeting.

Section 13.02 Special Meetings of the General Staff.

Special meetings may be called by the President of the Medical Staff at any time. The MEC shall designate the time and place of any special meeting. Written notice stating the place, date, and time of any special meeting of the Medical Staff shall be delivered either by e-mail, postal

service, or hand delivery to each member of the Active Staff, not less than three (3) nor more than ten (10) days before the date of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section 13.03 Quorum and Manner of Acting:

Not less than ten (10) members of the Active Medical Staff who are present in person shall constitute a quorum at any general or special staff meeting. The affirmative vote of the majority of the Active Medical Staff members present in person shall be the action of the Medical Staff.

Section 13.04 Committee and Department Meetings.

- A. 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. The frequency of such meetings shall be as required by these bylaws.
- B. Special meetings: A Special meeting of any committee or department may be called at the request of the chairman, the Board, the President/CEO or by one-third of the committee's or department's members. No business shall be transacted at any special meeting except that stated in the meeting notice
- C. Notice of meetings: Written notice stating the place, date, and time of any special meeting of the committee or department shall be delivered not less than three, nor more than ten, days before the date of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.
- D. Quorum: Not less than three (3) Active Medical Staff members of the department or committee who are present in person shall constitute a quorum at a clinical department or committee meeting.
- E. Manner of Action: The action of a majority of the members present in person at a meeting at which a quorum is present shall be the action of a committee or department. Proxy voting is not permitted.
- F. Telecommunications: Committee members may participate in any regular or special meeting by, or the meeting may be conducted through, the use of any means of communication by which all persons participating in the meeting may hear each other during the meeting. Any committee member participating in a Committee meeting by this means is deemed to be present in person at the meeting.
- G. Minutes: Minutes of each meeting shall be prepared by such person designated to take such minutes and should include a record of attendance and the vote taken on each matter. The minutes shall be signed by the presiding chairman or his designee. Each committee and department shall maintain a permanent file of the minutes of each meeting in the Medical Staff Office. A report shall be made to the MEC.

ARTICLE XIV

CONFIDENTIALITY, IMMUNITY AND RELEASES

The following shall be expressed conditions to any Physician's/Practitioner's application for, or exercise of, Clinical Privileges at this Hospital.

- A. Any act, communication, report, recommendation or disclosure, with respect to any such Physician/Practitioner, performed or made in good faith and without malice, and at the request of an authorized representative of this or any other health care facility, shall be privileged to the full extent permitted by law.
- B. Such privilege shall extend to members of the Hospital's Medical Staff and to its Governing Board, its other Physicians/Practitioners, its President/CEO and their representatives and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this article, the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the Governing Board or of the Medical Staff.
- C. There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation or disclosure, even where the information involved would otherwise be deemed privileged.
- D. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution activities related, but not limited to: 1) applications for appointment or Clinical Privileges, 2) periodic reappraisals for reappointment or Clinical Privileges, 3) corrective action, including summary suspension, 4) hearings and appellate reviews, 5) medical care evaluations, 6) utilization reviews, and 7) other Hospital, department or committee activities related to quality patient-guest care and inter-professional conduct.
- E. The acts, communications, reports, recommendations and disclosures referred to in this article may relate to a Physician's/Practitioner's professional qualifications, clinical competence, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care or relevance in the application for appointment or reappointment.
- F. In furtherance of the foregoing, each Physician/Practitioner shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this article in favor of the individuals and organizations specified in Paragraph B above, subject to such requirements, including those of good faith, absence of malice and the exercise of reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state.
- G. The consents, authorization releases, rights, privileges and immunities provided in these Bylaws for the protection of this Hospital's Physicians/Practitioners, other appropriate Hospital officials and personnel and third parties, in connection with applications for

initial appointment or reappointment, shall also be fully applicable to the activities and procedures covered by this article.

ARTICLE XV

POLICY FOR STAFF SELF-GOVERNANCE/RULES & 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 Medical Staff member 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 of the Active Staff by a vote of over 50% of the Active medical staff present in person or by proxy. Such changes shall become effective when approved by the Governing Board.

ARTICLE XVI

AMENDMENTS

These Bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff. Before being presented for amendment at a regular or special meeting of the Medical Staff, the proposed amendment shall be referred to the MEC, who shall report on it at the next regular meeting of the Medical Staff or at a special meeting called not less than 30 days following the MEC for such purpose. If significant changes are made in the Medical Staff Bylaws, members of the Medical Staff and other individuals, who have delineated clinical privileges, shall be provided with revised texts of the written materials. To be adopted, an amendment shall require a vote of the majority of the Active Medical Staff members present in person at a Medical Staff meeting to amend these Bylaws. Amendments so made shall be effective when approved by the Governing Board.

ARTICLE XVII

ADOPTION

These Bylaws together with the appended rules and regulations shall be adopted at any regular or special meeting of the Active Medical Staff and shall replace any previous Bylaws and rules and regulations and shall become effective when approved by the Governing Board.

BYLAWS OF THE MEDICAL STAFF OF COMMUNITY HOSPITAL

APPROVED ADOPTIONS AND REVISIONS:

Date: March 16, 2010

Medical Executive Committee

Date: March 17, 2010

Medical Staff

Date: March 31, 2010

Board of Trustees

Date _____

Date _____

Date _____

Date _____

Date _____

Date _____

Date _____
